



Name _____ DOB _____
 Address _____ City _____ ST _____ Zip _____
 Employer _____
 Best Time of Day To Contact You _____ Best Number to Call () _____
 Spouse/Significant Other Name _____ Employer _____
 Location and Date of Your Last Mammogram _____

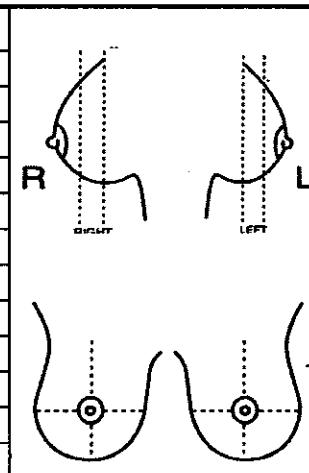
Reason For Visit Today (Mark all that apply today)				Signature
Lump or Mass	Y N	R L	How long?	
Thickening	Y N	R L	How long?	
Focal Pain	Y N	R L	How long?	
Tenderness	Y N	R L	How long?	
New Nipple Retraction	Y N	R L	How long?	
Nipple Discharge	Y N	R L	How long?	

Have You Ever Had a Core Biopsy on Your Breast Y N L R Year _____
 Have you had surgery showing Breast Cancer Y N L R Year _____
 Have you had Breast surgery that was not cancer Y N L R Year _____
 Have You had Breast Implants, Reduction or Breast Lift Y N Year _____
 Are You Post Menopausal or Have You Had your Ovaries Removed Y N How Long? _____
 Are You Taking Hormones (HRT) Y N How Long? _____

Risk

Have You or a Family Member Ever Had Genetic Testing Y N Who? _____
 Have You Ever Had a Breast MRI Y N
 Did You Have Radiation to Your Chest or Neck as a Child Y N Results _____
 Have You Had Radiation to the Chest for Lymphoma Y N
 Have You Had Atypical Hyperplasia or LCIS Y N

Family History	Breast	Ovarian	Other Types	Age Detected	Side of Family
Self					
Mother					
Father					
Sister(s)					
Brother(s)					
Children					Mother or Father
Grandmother					Mother or Father
Aunt(s)					Mother or Father
Cousin(s)					Mother or Father
Have you been diagnosed with Rheumatoid arthritis?				<input type="checkbox"/> Y <input type="checkbox"/> N	
If your family history indicates you may be at High Risk for Breast Cancer would you like to Speak to to Speak to a Genetic Counselor?				<input type="checkbox"/> Y <input type="checkbox"/> N	



I authorize the release of any medical information, including x-ray images, necessary to Women's Health Center for continuum of my breast health care.

Signature _____ Date _____



SCREENING BREAST HISTORY SHEET