

Breast Health History Form

Patient Name: _____

Today's Date: _____

Reason for today's visit: _____

1. Have you ever experienced any of the following?

An unresolved breast lump

Breast pain

Nipple discharge

Breast abnormality found on an exam

Significant breast trauma

Explain _____

Change in breast skin (dimpling, puckering, redness, etc.)

2. Date of last clinical breast exam/ physical: _____

3. Have you had previous breast imaging (mammogram, ultrasound, MRI, etc.)? Yes No

If yes, please specify the date and type of imaging completed.

4. Do you perform monthly self-breast exams? Yes No

5. Have you ever had a breast biopsy? Yes No

If yes, please specify when and whether it was a surgical biopsy or needle biopsy and diagnosis if known.

Please answer the following regarding hormone therapy and family history:

6. Do you or have you ever used hormone replacement therapy or steroids? Yes No

If yes, dates of use: _____

7. Do you have any family history of BREAST, COLON, OVARIAN, or PROSTATE CANCER? Yes No

If yes, please specify the type of cancer, family member and age diagnosed (ex: ovarian, maternal aunt, age 55):

Please answer below if applicable:

1. Beginning date of last period: _____

2. Age of first period: _____

3. How many times have you been pregnant? : _____

4. How many living children do you have? : _____

5. Are you currently nursing or have you ever nursed? Yes No

6. Have you ever taken oral contraceptives? Yes No

If yes, please list starting and ending dates: _____