

BREAST DISEASE HISTORY FORM

Name: _____ Today's Date: _____

GENERAL INFORMATION

Age: _____ Sex: _____
 Medication Allergies: _____ If yes, what type of reaction: _____
 Race: White ___ Black ___ Hispanic ___ Asian ___ Other _____
 Do you smoke? YES ___ NO ___
 If yes, for how long? _____ How much do you smoke each day? _____
 If you have stopped, how long ago did you stop? _____
 How much did you smoke prior to stopping? _____
 Do you drink coffee, tea, or beverages that contain caffeine? YES ___ NO ___
 If yes, how many per day? _____
 Do you drink alcoholic beverages? YES ___ NO ___ If yes, how many per day? _____
 Do you bruise easily? YES ___ NO ___

REASON FOR VISIT

How long have you felt the symptom in your breast? _____

Do any of the following apply to you:

| | Right | Left | Other (please explain) |
|------------------|-------|-------|------------------------|
| Breast Lump | _____ | _____ | _____ |
| Pain | _____ | _____ | _____ |
| Nipple Discharge | _____ | _____ | Color: _____ |
| Inverted Nipple | _____ | _____ | _____ |
| Skin Change | _____ | _____ | _____ |

Detected by: Self ___ Physician ___ Mammography ___ Ultrasound ___ Other ___

BREAST MEDICAL HISTORY

Date of last mammography: _____

Has your weight changed since your last mammography: YES ___ NO ___

Have you had breast surgery/cyst aspiration: YES ___ NO ___ If yes, please complete:

| | Right | Left | Approx. Date | |
|------------------------------|-------|-------|--------------|------------------|
| Cyst Aspiration | _____ | _____ | _____ | |
| Breast Biopsy (Benign Cyst) | _____ | _____ | _____ | Diagnosis: _____ |
| Breast Implants | _____ | _____ | _____ | |
| Mastectomy | _____ | _____ | _____ | |
| Lumpectomy/Radiation Therapy | _____ | _____ | _____ | |
| If other, please explain | _____ | | | |

MENSTRUAL/PREGNANCY HISTORY

Age at first menstrual cycle: _____ Periods: Regular _____ Irregular _____
 Date of most recent period: _____
 Number of Pregnancies: _____ Miscarriages: _____ Abortions: _____
 Number of Children: _____ Age of First Delivery: _____ Age at Last Delivery: _____
 Did you breast feed? _____ For how long? _____
 Menopause: No _____ Natural _____ Surgical _____
 Have you had a hysterectomy? YES ___ NO ___ Ovaries removed? YES ___ NO ___
 Are you taking: Hormones: ___ Birth Control Pills _____ Fertility Pills ___ Other _____
 If yes, how long have you been taking it? _____ When did you begin taking it? _____
 When did you last take it? _____

FAMILY HISTORY OF BREAST CANCER

Please check and indicate age at diagnosis

Maternal: None ___ Mother ___ Age _____ Grandmother ___ Age _____ Aunt ___ Age _____
 Sister ___ Age _____ Daughter ___ Age _____ Cousin ___ Age _____
 Other _____ Age _____
 Paternal: None ___ Father ___ Age _____ Grandmother ___ Age _____ Aunt ___ Age _____
 Sister ___ Age _____ Daughter ___ Age _____ Cousin ___ Age _____
 Other _____ Age _____
 Personal: NO ___ YES ___ Site: _____ Approx. Date: _____

FAMILY HISTORY OF OTHER CANCERS

Please indicate relationship, site of cancer, and age at diagnosis

Maternal Relative _____ Site _____ Age _____

Paternal Relative _____ Site _____ Age _____

ANCESTRY AND CLINICAL HISTORY

Western/Northern Europe _____ Africa _____
 Ashkenazi _____ Asia _____
 Central/Eastern Europe _____ Neareast/Mideast _____
 Latin American/Caribbean _____ Native American _____ Other _____

Religion: _____ **Marital Status:** _____