PATIENT BREAST INFORMATION

NAME:_____AGE:_____DATE:___/_____/_____

**PERSONAL BREAST HISTORY**

PREVIOUS BREAST BIOPSY YES NO IF YES-WHEN_____

PREVIOUS BREAST SURGERY YES NO IF YES-WHEN_____

WHAT TYPE_____

**FAMILY HISTORY OF BREAST CANCER** YES NO

IF YES: MOTHER___AGE_____ SISTER(S)___AGE_____ AUNT(S)___AGE_____

GRANDMOTHER___AGE____ DAUGHTER___AGE____ OTHER_____

**MENSTRUAL HISTORY:**

1st MENSTRUAL CYCLE-AGE____ MENOPAUSE-AGE_____

LAST MENSTRUAL CYCLE_____

HORMONE USE: ORAL CONTRACEPTIVE_____ HORMONE REPLACEMENT_____

**CHILDBIRTH HISTORY**: # OF PREGNANCIES_____# OF CHILDREN_____

AGE AT 1ST LIVE BIRTH_____ BREAST FEEDING HISTORY YES NO

DO YOU DO REGULAR SELF BREAST EXAMS NO YES HOW OFTEN?
DO YOU HAVE CAFFIENE REGULARLY? NO YES SOURCE AND HOW OFTEN?
ARE YOU ON BLOOD THINNERS? NO YES
DO YOU HAVE A PACEMAKER/DEFIBRILLATOR? NO YES

| | | | |
|---|---|---|---|
| MAMMOGRAM | YES | NO | DATE OF EXAM_____ |
| BREAST US | YES | NO | DATE OF EXAM_____ |
| BREAST MRI | YES | NO | DATE OF EXAM_____ |

**REASON FOR TODAYS VISIT:**

BREAST LUMP RT LT FIRST NOTICED_____

BREAST PAIN RT LT FIRST NOTICED_____

NIPPLE DISCHARGE RT LT FIRST NOTICED_____

CHANGE IN BREAST APPEARANCE: RT LT FIRST NOTICED_____

ABNORMAL MAMMOGRAM RT LT

SECOND OPINION

**PREVIOUS BREAST CANCER TREATMENT** YES NO

LUMPECTOMY YES NO RT LT

RADIATION THERAPY YES NO RT LT

MASTECTOMY YES NO RT LT WHEN?_____
WITH OR WITHOUT RECONSTRUCTION

CHEMOTHERAPY YES NO