

BREAST HISTORY FORM

Name: _____ Date: _____

DOB: _____ Phone: _____

Referring Physician: _____

Yes No Is this your first mammogram?
If no, how long since your last mammogram? _____ Yrs
Where was it done? _____

Yes No Do you have a personal history of Cancer?
 Breast Endometrial (Uterus) Ovarian Colon Other

Yes No Is there a family history of breast cancer?
 Aunt, grandmother, cousin Mother Daughter Sister Sister
Before menopause? Aunt, grandmother, cousin Mother Daughter Sister Sister

Breast Surgical and Treatment History: _____

Yes No Do you have implants? Both Right Left How long? _____
 Silicon Saline Any problems? _____

Yes No Have you had reduction surgery? When? _____

Yes No Are you currently taking hormones? If yes, how long? _____

Reason for exam
 Screening (no current problems)
 I am having a breast problem
 A new lump that can be felt Left Right
 Nipple discharge Left Right Color _____
 Pain in breast Left Right
 Implant problem Left Right
 Other _____
 Additional exam requested from prior mammogram

Yes No Any injury to either breast? If yes, explain: _____

Yes No Do you examine your own breasts? How often? _____

Yes No Has a physician examined your breast in the past year?

Age at first Menstrual period? _____ Date of last Menstrual period _____

Age of menopause? _____ If hysterectomy, what age _____