Last Name: _____ First: _____ MI: ___
DOB ___/___/____ Referring Physician: _____
Date of Last Mammogram: _____
Location of last mammogram: _____

OFFICE USE ONLY:
Patient MRN:_____
Patient Appt Date:_____
Patient Appt Time :_____

Please answer yes or no and the questions below:

Are you currently pregnant? Yes ____ No ____
Are you currently breastfeeding? Yes ____ No ____ Age at First Period? _____
How many pregnancies have you had? ____ #of live births? ____ Age at first childbirth? _____
Date of your last menstrual period? _____
Have your ovaries been removed? Yes ___ No ___
Has your uterus been removed? Yes ___ No ___

Please check the appropriate answer. I am having the following ***NEW*** breast problem:

Lump(s)	No Problems ____	Right breast ____	Left breast ____	Both breasts ____
Pain	No Problems ____	Right breast ____	Left breast ____	Both breasts ____
Nipple discharge	No Problems ____	Right breast ____	Left breast ____	Both breasts ____

Other problem: _____

Have you had any of the following? (Please check all that apply)

Breast Implants	Yes ___ No __	Please check type: Silicone ____ Saline ____
Breast Lift	Yes ___ No ___	
Breast Reduction	Yes ___ No ___	
Benign Surgical Biopsy *(not cancer)*	Yes ___ No ___	Right-# BXS __ Left -# BXS __ Atypical Changes? ____
Needle Core Biopsy	Yes ___ No ___	*Atypical Changes?* ____
Lumpectomy (***for breast CA***)	Yes ___ No ___	Right (date :_____) Left (date: _____)
Mastectomy *(for breast CA)*	Yes ___ No ___	Right (date: _____) Left (date: _____)
Radiation Therapy *(for breast CA)*	Yes ___ No ___	Partial breast radiation ___ Whole breast radiation___
Chemotherapy *(for breast cancer)*	Yes ___ No ___	
Antihormonal Therapy	Yes ___ No ___	

If diagnosed with breast cancer, what was your age when you were diagnosed? ____

Are you currently or have you ever taken any of the following? (Please check all that apply)

Birth control	Never ____	Currently____	For how long? ____	*Previously* ____	For how long? ____
Fertility drugs	Never ____	Currently ____	For how long? ____	*Previously* ____	For how long? ____
Hormones	Never ____	Currently ____	For how long? ____	*Previously* ____	For how long? ____

If yes to hormones, please ✓ which type Synthetic ____ Bio-identical ____

Has any family member ever been diagnosed with **breast cancer?** (Please check all that apply)

Mother:	Age at diagnosis _____			
Sister (s):	Age at diagnosis _____			
Daughter(s):	Age at diagnosis _____			
Grandmother:	Age at diagnosis _____	(please✓)	Mother's side ____	Father's side ____
Aunt(s):	Age at diagnosis _____	(please✓)	Mother's side ____	Father's side ____
Other: _____	Age at diagnosis _____	(please✓)	Mother's side ____	Father's side ____

Are you of Ashkenazi Jewish Descent? Yes ____ No _____

Have you or a family member ever been diagnosed with **ovarian cancer**? Yes __ No __ Relationship _____
Have you or a family member had genetic testing for breast cancer risk? Yes __ No __ Relationship _____
Have you had radiation to the chest for lymphoma or other cancer? Yes __ No __ Age _____
Please list any other cancers in your family: (family member, type, age diagnosed)

_____
_____
_____

Patient signature: _____ Date: _____

$	Dr.	Follow -up	2014v5