THE UNION HOSPITAL
Breast Health CENTER

Patient Name: _____

Date of Birth: _____

BREAST HEALTH HISTORY FORM

Name: _____ Date of Birth: _____

Today's Date: _____ Age: _____ Height: _____ Weight: _____

Reason for Today's Visit:

□ Routine screening (No known problems)
□ Baseline (First Mammogram
□ Short Term follow up after _____ month(s)
□ Breast Problem **(See below)**

New Lump	□ Right	□ Left	□ Both
Nipple Discharge	□ Right	□ Left	□ Both
Nipple Skin Retraction	□ Right	□ Left	□ Both
Swelling	□ Right	□ Left	□ Both
Breast Pain	□ Right	□ Left	□ Both
Rash/ Scaling/ Itching	□ Right	□ Left	□ Both
Other (Please Specify): _____	□ Right	□ Left	□ Both

Previous Mammogram? □ No □ Yes **(Please specify)** Date of Exam: _____ Name of Facility: _____

Clinical History:

Age at First Period: _____ **Age at First Full Term Pregnancy:** _____ **Number of Live Births:** _____

Post-Menopausal Women	Premenopausal Women
Currently in Menopause? □ Yes □ No	Currently using Birth Control? □ Yes □ No
Age at Menopause (no periods for one year) _____	IUD? □ Yes □ No
Did you have a hysterectomy? □ Yes □ No Ovaries Removed? □ Right □ Left □ Both	Date of Last Menstrual Period? _____
If yes, how old were you? _____	Is there any chance that you could be pregnant? □ Yes □ No

Hormone Use? □ Yes □ No
Currently taking hormones? □ Yes □ No
How many years are you planning to take hormones? _____
Please Identify: □ Estrogen Only □ Progesterone Only □ Combination
Previously taken hormones? □ Yes □ No Start Date: _____ Stop Date: _____
Currently taking? □ Tamoxifen □ Femara □ Arimidex

Have you been tested for the BRCA gene? □ Yes □ No
If yes, results? □ Normal □ BRCA 1 □ BRCA 2 □ Indeterminate
Do you have a personal history of the following?
Ovarian Cancer? □ Yes □ No If yes, age at diagnosis: _____
Personal History Breast Cancer? □ Yes □ No If yes, age at diagnosis: _____

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BREAST HEALTH HISTORY FORM

Breast Surgical History:

	Date:	
Implants:		□ Right □ Left Type of Implant:
Breast Reduction:		□ Right □ Left
Cyst Aspiration:		□ Right □ Left
Biopsy:		□ Right □ Left Result:
Lumpectomy:		□ Right □ Left For Cancer: □ Yes □ No
Mastectomy:		□ Right □ Left
Radiation Therapy:		□ Right □ Left □ Bilateral
Chemotherapy		
Other:		

Family History:

Ashkenazi Inheritance (Eastern European Jewish Heritage)? □ Yes □ No

As well as your immediate family, think about the family members on both your mother and fathers side (female and male) Grandparents, aunts, uncles and **FIRST** cousins**. Indicate P for Fathers side and M for Mothers side.**

Is there any family history of Breast or Ovarian cancer? □ Yes □ No

If yes, please supply the following to the *best of your knowledge*.

Relation to you	P/M	Ovarian or Breast (Both)	Age of Diagnosis	Age at Death/ Age Now (if appropriate)

Patient Signature: _____

DO NOT WRITE- THIS SECTION TO BE COMPLETED BY BREAST HEALTH STAFF

Lifetime Risk (Tyrer-Cuzick) calculated as _____

With breast density from date _____ / Recalculated _____

□ Fatty □ Average □ Heterogeneous □ Extremely

□ Pathology on previous biopsy confirmed/unknown
□ Recent weight loss >10 lbs
□ Breast larger than the other? □ Right □ Left
□ Noticeable change in breast size? □ Right □ Left

	QUARDRANT
□ Lump felt by patient/ provider	
Discharge: □ Bloody □ Purulent □ Clear How Long? _____	
□ Pain	

Tech Review: _____

* B H C *