ChristianaCare

ENCBASFRM

Cecil Campus

BREAST HEALTH HISTORY

Instruction:
To be completed by patient prior to visit.

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
Did you have a hysterectomy? ☐ Yes ☐ No	IUD? ☐ 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: _____

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	_____ /_____ /_____	

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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 father's side (female and male. Grandparents, aunts, uncles and FIRST cousins. Indicate P for Father's side and M for Mother's 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)

_____ _____ ___/___/___ _____
Signature of Patient or Decision Maker | Relationship to Patient | Date | Time

_____ _____ ___/___/___ _____
Technologist Signature | Print Name or ID# | Date | Time

Interpretation: The information has been presented to the: ☐ Patient ☐ Representative ☐ Decision Maker in: _____ Language
The person who provided the interpretation is a qualified medical interpreter.

_____ _____
Interpreter Name | Agency and ID# (if applicable)

_____ _____ ___/___/___ _____
Witness Signature/Title | Print Name or ID# | Date | Time