

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Do you currently have a breast lump that you can feel?  Yes  No

When was the problem first noticed? \_\_\_\_\_

Which Breast?  Right  Left

Was it noted by another physician on examination?  Yes  No Date: \_\_\_\_\_

Physician: \_\_\_\_\_

Has the lump changed in size?  Yes  No

Does its size vary with your menstrual cycle?  Yes  No

Do you have nipple discharge?  Yes  No If yes, what is the color? \_\_\_\_\_

Which breast?  Right  Left

Spontaneous  Evoked

Have you had a recent:

Mammogram  Yes  No;

Date of study \_\_\_\_\_

Where \_\_\_\_\_

Ultrasound  Yes  No;

Date of study \_\_\_\_\_

Where \_\_\_\_\_

MRI?  Yes  No;

Date of study \_\_\_\_\_

Where \_\_\_\_\_

Have you ever had a breast biopsy?  Yes  No

If yes, which breast was tested? \_\_\_\_\_

Type of Biopsy Performed?  Fine Needle

Aspiration  Surgical Incision  Stereotactic  Core Needle

Please indicate when this occurred, the facility, and the result:

Date: \_\_\_\_\_

Place: \_\_\_\_\_

Physician: \_\_\_\_\_

Result: \_\_\_\_\_

Do you take hormones?  Never  Not now, but in the past for \_\_\_\_\_ years  Yes, for \_\_\_\_\_ years

Birth control pills:  Never  Yes, but I stopped (how long ago \_\_\_\_\_)  I am currently taking  Never

Age of menstrual onset? \_\_\_\_\_ Is your cycle regular?  Yes  No

Last menstrual period? \_\_\_\_\_

Have you gone through menopause?  Yes  No Age of onset \_\_\_\_\_  Naturally  Surgically

Pregnancies: How many? \_\_\_\_\_ Any abortions or miscarriages? \_\_\_\_\_

Number of deliveries (vaginal or cesarean)? \_\_\_\_\_

Age of first delivery? \_\_\_\_\_ Did you breast feed?  No  Yes – how long? \_\_\_\_\_

Do you have a personal history of breast cancer?

No  Yes

Do you have any other type of cancer?  No  Yes

If yes, what kind: \_\_\_\_\_

Do you have a family history of breast cancer?

Yes  No

If yes, please indicate the relationship to you and age of onset (if known):  
\_\_\_\_\_  
\_\_\_\_\_

Do you have a family history of:

Ovarian Cancer  Yes  No;

Prostate  Yes  No;

Colon  Yes  No;

Melanoma  Yes  No;

Endometrial  Yes  No;

Pancreatic  Yes  No

If yes, please indicate the relationship to you and age of onset (if known), as well as the type of cancer:  
\_\_\_\_\_  
\_\_\_\_\_

Additional cancers in the family \_\_\_\_\_  
\_\_\_\_\_