THE Breast CENTER
Specialists In Breast Care

LAST NAME: _____ FIRST:_____ MI: _____

DATE: _____ DOB: _____ ACCT #: _____

REASON FOR OFFICE VISIT:

Which doctor referred you today?			_____
Are you a new patient to The Breast Center?	Y	N	
Is this a follow up exam?	Y	N	
Do you feel a new breast lump?	Y	N	If yes, which breast and for how long?_____
Do you have an abnormal mammogram?	Y	N	
Do you have nipple discharge?	Y	N	If yes, which breast and color of discharge?_____
Do you have breast pain?	Y	N	If yes, which breast and for how long?_____
Do you have skin changes?	Y	N	If yes, which breast and describe?_____

PAST MEDICAL HISTORY:

Do **you** have a history of breast cancer?	Y	N	
If yes, which breast?	R	L	Lumpectomy or mastectomy?_____
Radiation therapy?	Y	N	
Chemotherapy?	Y	N	
Antiestrogen medications?	Y	N	If yes, list (Tamoxifen, Arimidex, etc)_____
Do **you** have a history of ovarian cancer?	Y	N	
Do **you** have a history of any other cancers?	Y	N	If yes, list _____
Do **you** have a history of mastitis/breast infections?	Y	N	
Do **you** have a history of breast injuries or trauma?	Y	N	
Do **you** have a history of breast cysts?	Y	N	
Are **you** taking hormones (estrogen,progesterone)?	Y	N	If yes, list _____
Are **you** taking Birth Control Pills?	Y	N	

SOCIAL HISTORY:

Do you smoke?	Y	N	If so, how many per day? _____
Did you smoke in the past?	Y	N	How long ago did you quit? _____
Do you drink alcohol?	Y	N	How often? _____
Do you drink caffeine?	Y	N	How often? _____
Do you exercise?	Y	N	How often? _____

REPRODUCTIVE HISTORY:

Age of 1st menstrual cycle	_____		
Age of 1st pregnancy	_____		
Age of menopause	_____		
Date of your last pap smear	_____		
Are **you** pregnant?	Y	N	If yes, due date _____
Are **you** breast feeding?	Y	N	

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FAMILY HISTORY:
List any family members that have the following medical conditions:

High Blood Pressure _____ Heart Attack _____Heart Failure _____
Stroke _____Diabetes _____

Family members with **Breast Cancer**? - Y N (if yes, list age at diagnosis)

First Degree relatives: Mother _____ Sister(s) _____ Daughter(s) _____

Mother's Side: Grandmother _____Aunt(s) _____Cousin(s) _____Men_____

Father's Side: Grandmother _____Aunt(s) _____Cousin(s) _____Men _____

Family members with **Ovarian cancer**? Y N please list_____
Uterine cancer? Y N _____
Prostate cancer? Y N _____
Pancreatic cancer? Y N _____

YOUR PAST SURGICAL HISTORY:
Name and dates of operations and/or Biopsies:

1. _____
2._____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

METALIC IMPLANTS:
Do you have any of the following:

Pacemaker	Y	N
Stimulator	Y	N
Stent	Y	N
Aneurysm Clip	Y	N

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HEALTH INFORMATION **-** Circle Yes or No

General
Weight loss Y N
Weight gain Y N
Current weight _____
Current height _____

Other skin symptoms
Skin problems Y N
Rashes Y N
Other: _____

Ear, Nose and Throat
Earache Y N
Hearing Loss Y N
Nose bleeds Y N
Nasal discharge Y N
Mouth sores Y N
Throat pain Y N
Other: _____

Heart
Rapid heartbeat Y N
High blood pressure Y N
Are you taking blood thinners? Y N
Other: _____

Lung symptoms
Asthma (wheezing) Y N
Other: _____

Endocrine symptoms
Thyroid Disorders Y N
Diabetes Y N
Other: _____

Infectious Diseases
HIV/ AIDS Y N
Hepatitis B Y N
Hepatitis C Y N

Bone and Joint symptoms
Joint pain Y N
Muscle Aches Y N

Neurological
Difficulty moving arms/legs Y N
Fainting Y N
Headaches Y N
Do you use a cane, walker, or wheelchair Y N
*if so, do you have frequent falls Y N

Lymphatic symptoms
Neck pain Y N
Lump in neck Y N
Lump in armpit Y N
Other: _____

Gastrointestinal symptoms
Decreased appetite Y N
Heartburn Y N
Other: _____

Bleeding disorders
Do you have any bleeding problems? Y N
Do you tend to bruise easily Y N
Other:_____

Psychological symptoms
Sleep disturbances Y N
Anxiety Y N
Depression Y N
Other: _____

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ALLERGIES:

*No known or list below

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Are you allergic to IV Contrast? Yes No

MEDICATIONS:

Please list dosage and frequency

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

General Breast Health Questions

Y N Have you been instructed to perform breast self examinations?
Y N Do you examine your breasts monthly?
Y N Have you ever had a breast mammogram? If so, when was your last mammogram prior to today?
Y N Do you understand that it is recommended to have a yearly breast examination by a health care provider?
Y N Do you understand that very tiny breast cancers may not be felt by your doctor and that is why repeat examinations are necessary?
Y N Do you understand that mammograms are very helpful, but that not all breast cancers can be seen on x-ray or ultrasound?

□ Please check if you have had any changes in your health in the past year.

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____