

## Breast History Form

Name: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Last First Middle Initial Month Day Year

DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**REASON FOR VISIT:**

(Check all that apply.)

- Skin Changes       Lump(s)       Breast Pain  
 Nipple Discharge       Abnormal Mammogram/Ultrasound  
 Other    *If other, please describe:* \_\_\_\_\_

**PREVIOUS BREAST BIOPSY:** How Many: \_\_\_\_\_

Date/Result of Each:


**PREVIOUS HISTORY:**

(Check all that apply.)

- Breast Cancer       Ductal Carcinoma in Situ       Lobular Carcinoma in Situ  
 Atypical Ductal Hyperplasia       History of Radiation Therapy to Chest

How many children: \_\_\_\_\_ Did you breastfeed?:  Yes  No

Age at first pregnancy: \_\_\_\_\_ Age when you started having menstrual periods (menarche): \_\_\_\_\_

Age when you reached menopause (if applicable): \_\_\_\_\_

Do you take oral contraceptives?:  Yes  No    If yes, how many years?: \_\_\_\_\_

Do you take hormone replacement therapy?:  Yes  No    If yes, how many years?: \_\_\_\_\_

**FIRST DEGREE FEMALE RELATIVES:** (ex. mother, sister, daughter) with history of breast cancer and/or ovarian cancer

Family history of breast cancer?:  Yes  No    If yes, please fill section below. (Check all that apply.)

Name / Age (Current) / Relationship / Age of Diagnosis	Breast Cancer?	Ovarian Cancer?
1)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No



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## Breast History Form

Patient Name: \_\_\_\_\_ DOB: \_\_\_ / \_\_\_ / \_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_

**ADDITIONAL NOTES:** Write any notable information not included in the form.