BREAST HISTORY

Patient name: _____ Date: _____

Is there a history of breast cancer in your family? ○ Y ○ N

If yes, please specify who: Mother ○ Sister ○ Daughter ○ Other ○

Is there a history of other breast disease in your family? ○ Y ○ N

If so, please explain _____

Do you take birth control pills? ○ Y ○ N

Do you take any hormone medication? (i.e. estrogen)? ○ Y ○ N

If yes, what medication? _____

Have you ever had breast surgery? ○ Y ○ N

If yes, please explain _____

Have you ever had surgery on your reproductive organs (i.e. hysterectomy, removal of ovaries)? ○ Y ○ N

If yes, please explain _____

Have you ever had abdominal surgery (i.e. tummy tuck, gallbladder removal, laparotomy)? ○ Y ○ N

If yes, please explain _____

Detail your pregnancies with dates and type of delivery (vaginal/cesarean section).

_____

_____

Do you plan to have any future pregnancies? ○ Y ○ N

What's your current weight? ____ft ____in. Weight? ____lbs. Ideal weight? _____lbs.

What's your current bra size? _____

Has your breast significantly changed in size with weight fluctuation, pregnancies, or menstruation? ○ Y ○ N

Date of your last mammogram _____ Findings _____

Do you perform periodic breast self-examinations? ○ Y ○ N

CLEAR