

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Age of First Period: \_\_\_\_\_ Age at Birth of 1<sup>st</sup> Child \_\_\_\_\_

Have you gone through menopause? YES or NO Age of menopause: \_\_\_\_\_ or Date of last period: \_\_\_\_\_

Have you ever used Hormone Replacement Therapy? YES or NO  
How long? \_\_\_\_\_ If previous use, when did you quit taking? \_\_\_\_\_

Please list physicians you would like to receive today's results:

PCP (Primary Care Physician) \_\_\_\_\_ OB/GYN: \_\_\_\_\_

Other Physicians: \_\_\_\_\_

PLEASE answer ALL of the following questions. **CIRCLE** the appropriate answers and/or fill in the blanks.

1. ARE YOU PREGNANT NOW? YES NO

2. When was your last mammogram? \_\_\_\_\_ Where? \_\_\_\_\_

3. Did you experience discomfort during your last mammogram? 1 2 3 4 5  
Minimal Moderate Severe

4. Why are you having this breast study? Routine/Yearly YES NO

Do you feel <b>ANY LUMPS TODAY?</b>	YES	NO	RT	LT	How long _____
Breast Pain or soreness today?	YES	NO	RT	LT	How long _____
Any Discharge from Nipple?	YES	NO	RT	LT	Color or Discharge _____ How long _____
Any nipple changes on your breast?	YES	NO	RT	LT	

5. Have you ever had breast cancer? . . . . . YES NO

When? \_\_\_\_\_ What age? \_\_\_\_\_ Which breast(s) . . . . . Right Left

Type of breast cancer?  DCIS  Invasive Ductal  Invasive Lobular  
Other \_\_\_\_\_

What surgery/treatment(s) did you have?  Lumpectomy  Mastectomy  
 Radiation  Chemotherapy  Tamoxifen  Evista  Other \_\_\_\_\_

6. Have you had a breast biopsy or surgery for reasons **OTHER** than for breast cancer? YES NO

Type of surgery:  Biopsy  Implants  Reduction  Breast lift  Other: \_\_\_\_\_

How many surgeries? Right \_\_\_\_\_ Left \_\_\_\_\_

When (year)? Right \_\_\_\_\_ Left \_\_\_\_\_

Result:  Benign  Hyperplasia  Atypical Hyperplasia  LCIS

7. What is your race?  Caucasian  African American  Hispanic/Latino  Asian  
 Ashkenazi Jewish Other \_\_\_\_\_

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