HealthPoint
Medical Group

BREAST HISTORY

Patient Name: ____________________________ Date of Birth:________ Today's Date: ________

The following information helps us evaluate your risk for developing breast cancer. Please complete as many of the questions as possible. It is certainly acceptable to give approximate dates, ages, etc. If additional space is needed you may use the back of the form or ask us for a blank sheet of paper.

Please circle your racial background(s): White Black Asian Hispanic Native American

Age at first menstrual period:__________________
Age at last menstrual period: __________________
If still having periods, date of last menstrual period: __________________
If you have had a hysterectomy, were your ovaries also removed? __________________

Number of pregnancies: __________________
Age at first delivery: __________________
Number of deliveries: __________________
If you breast fed, approximate length of time you did so: __________________

Have you used birth control pills? ________ If so, please give approximate ages during use.
____

Have you been on any hormone replacement therapy? __________ If so, please give name and doses of medication and the approximate duration of treatment. ______________________________________
____

Do you have a family history of breast or ovarian cancer? __________If so, please give the person's age at time of detection and their relationship to you.____
____

Have you ever had breast or ovarian cancer? __________________
Have you ever received radiation therapy to your chest area?__________________________________

Have you ever had a breast biopsy? ___________ If so, please list when, where and the name of the doctor who performed the biopsy. ____
____
____

Please list the results of the biopsy and give us a copy, if you have one.__________________________
____
____

Have you ever had any other breast surgery? ___________ If so, please list when, where, and what procedure was performed.____
____
____

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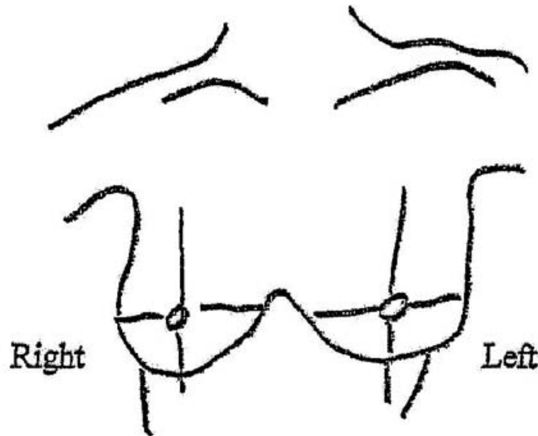
Do you/ your doctor/ both you and your doctor feel a lump in your breast? _____________________

If yes, please circle above who feels the lump, and also indicate below the location of the lump(s).



Have you had any nipple discharge? _________________________________

Have you experienced any new/unusual breast pain?___________________

Have you had a recent mammogram? _____ If so, when and where: _____________________
____

Have you had mammograms in the past? _____ If so, when and where:____________________
____
____
____

Have you ever been told you had an abnormal mammogram? _____ If so, when and where was it done, and what recommendations did you receive? ____________________________________
____
____

Have you had breast ultrasounds performed? _____ If so, when and where: ________________
____
____

Have you ever been told you had an abnormal ultrasound of the breast? ____________________

If so, when and where was it done, and what recommendations did you receive? ____________
____
____
____

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