



BREAST HISTORY QUESTIONNAIRE

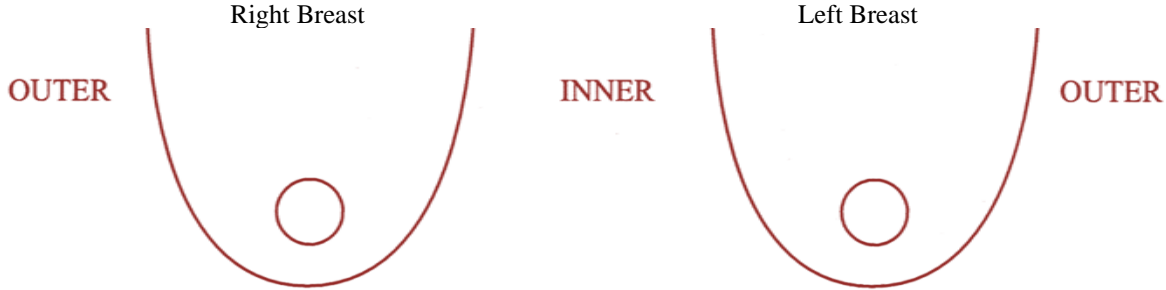


Name: _____ Date: _____ DOB: _____ Age: _____ Phone/Cell: _____

Why are you requesting a breast evaluation? Please check all that apply and tell us more on the space below.

- Routine Check (**If** you have no specific breast concerns then check this box and **skip to the next section**)
 - Abnormal Imaging exam (abnormal mammogram, Ultrasound or MRI)
 - Nipple Discharge or Breast Pain (please circle which one)
 - Breast lump or thickening: Approximate date it was first discovered? _____
Do you do monthly breast self exams (circle)? YES NO
Please draw the size and location on the diagram below
 - Other reason (please state the reason here): _____

Please draw the size and location of any breast lumps/thickening and/or scars if present on the diagram below.



Surgical History: Circle all that apply below & write in the YEAR after it. Draw any SCARS on the above diagram.

Cyst Aspiration (side L R) _____ Lumpectomy for Cancer (side L R) _____ Mastectomy(side L R) _____

Stereotactic/Ultrasonic (L R) _____ Radiation Therapy (side L R) _____ Reconstruction(side L R) _____
Needle Biopsy

Surgical Biopsy (side L R) _____ Augmentation (Breast Implants) _____ Reduction/Uplifting breasts _____

Imaging Log: (if not or never done write "NONE" in the appropriate box so that all boxes are filled)

Mammogram	Date	Facility	of Last Mammogram (or this one)	Date	Facility	of next to Last Mammo
Ultrasound	Date	Facility	of Last Ultrasound (or this one)	Date	Facility	next to last ultrasound
MRIs	Date	Facility	of Last MRI (or this one)	Date	Facility	of next to last MRI

Menstrual History: How many live births have you had? _____ When was your last menstrual period? _____

How many years total have you taken Estrogen Hormones? Never or _____ Years Are you taking Estrogen medications now? YES NO

Is it possible you could be pregnant now? YES NO (if yes, inform the staff verbally) Are you breast feeding now? YES NO

Who performed your last breast exam and when?

Do you have a PERSONAL or FAMILY HISTORY of breast cancer of any type?

NO YES If yes, Please tell us more on the reverse side of this form

Please to use this space if needed to tell us more:

Please use the margin of both pages to elaborate on your answers. Circle answers where appropriate. Thank you

Your current Age: _____ Age of first menstrual period: _____ Age at first live birth: _____ (if none, record "0")	
Do you have a personal history of chest wall radiation as treatment for Hodgkin's/lymphoma?	YES NO
Do you have a personal history of OVARIAN Cancer? (please circle)	YES NO
Do you have a personal history of BREAST MALIGNANCY of any type including Invasive Breast Cancer or Ductal (DCIS) or Lobular (LCIS) Carcinoma-in-situ?	YES NO
IF YES , at what age were you diagnosed? _____ On which side? Left Right	
FAMILY HISTORY of BREAST/OVARIAN CANCER: (if adopted or not sure, omit this section and check this box <input type="checkbox"/>) INCLUDE MALES with breast cancer. After "Relative" insert the relation of relative to you, i.e. mother, sister, grandmother, aunt etc.	
Please check <u>ONE</u> of the boxes below:	
<input type="checkbox"/> I <u>DO NOT</u> HAVE A FAMILY HISTORY OF BREAST OR OVARIAN CANCER (if checked go on to next section)	
<input type="checkbox"/> I <u>DO</u> HAVE A FAMILY HISTORY OF BREAST OR OVARIAN CANCER & THAT RELATIVE IS LISTED BELOW:	
Relative: _____ Age at Diagnosis: _____ Breast or Ovarian	(circle) (circle if aunts, grandmothers) Mother or Father's side
Relative: _____ Age at Diagnosis: _____ Breast or Ovarian	Mother or Father's side
Relative: _____ Age at Diagnosis: _____ Breast or Ovarian	Mother or Father's side
IF MORE SPACE IS NEEDED, PLEASE USE THE BOTTOM MARGIN OF THIS PAGE.	
What is your race/ethnicity? (circle) White Black Hispanic Asian or Pacific Islander Native American Not Sure	
Are you of Ashkenazi Jewish ancestry? (circle)	YES NO Not Sure
Have you ever had any kind of a breast biopsy? (circle)	YES NO (if no, skip next 2 questions)
How many breast biopsies- positive or negative-have you had? (Circle)	None 1 >1
Have you had at least one biopsy revealing <u>atypical ductal hyperplasia</u> ?	YES NO Not Sure
I attest to the accuracy of the questions I answered on both sides of this form. I authorize all facilities where I have had prior breast imaging to release to this facility breast images and reports done on me for comparison purposes.	
I acknowledge and accept the fact that current clinical and imaging technologies and their human interpretation have significant limitations and therefore I may harbor a cancer that is not perceived at this time. I have a right and an obligation to obtain the printed results of all imaging and pathology tests performed.	
Signature: _____	Date: _____
DO NOT WRITE BELOW: FOR OFFICE USE ONLY	
5 year risk this patient: _____%	5 year risk for average woman same age: _____%
Lifetime risk this patient: _____%	Lifetime risk for average women (to age 90): _____%
The Prevalence of Deleterious Mutations in <i>BRCA1</i> and <i>BRCA2</i> _____% CWR: Yes No	