

# Breast Health History Form

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Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

How did you find out about our services? Example: Google, Doctor, friend, etc. \_\_\_\_\_

Please provide an email address we can send your results to: \_\_\_\_\_

Do you have any family history of breast cancer?  Self  Mother  Sister  Daughter  None  
Maternal –  Grandmother  Aunt  Cousin Paternal –  Grandmother  Aunt  Cousin

Do you have any diagnosed breast conditions?  None  Fibrocystic  Cystic  Other \_\_\_\_\_

When was the date of your last mammogram? \_\_\_\_\_

Was it:  Normal  Abnormal  Suspicious  Something is being watched –  R  L Breast

When was the date of your last breast ultrasound? \_\_\_\_\_ Were both breasts imaged?  Y  N

Was it:  Normal  Abnormal  Suspicious  Something is being watched –  R  L Breast

Date of last physical breast exam by a doctor \_\_\_\_\_  Normal  Lump found –  R  L Breast

Any breast biopsies? When and what type (i.e. needle, excisional)? \_\_\_\_\_  R  L Breast

What was found on the biopsy?  Cancer  Other \_\_\_\_\_  R  L Breast

Any breast surgeries? When and what was done? \_\_\_\_\_  R  L Breast

Have you had a mastectomy? If yes, when? \_\_\_\_\_  R  L Breast

Any breast reconstruction? When and what was done? \_\_\_\_\_  R  L Breast

If you have had any radiation treatment, when was it last performed? \_\_\_\_\_  R  L Breast

Are you currently pregnant?  Y  N Current cycle day (number of days since first day of period) \_\_\_\_\_

If you've used birth control pills, at what age did you start? \_\_\_\_\_ How many years have you taken them? \_\_\_\_\_

Are you currently taking them?  Y  N

If you have passed menopause, at what age did it begin? \_\_\_\_\_

If you are taking hormone replacement, at what age did you start? \_\_\_\_\_ How many years taken? \_\_\_\_\_

Are you currently taking hormones?  Y  N (check only if by prescription):  Estrogen  Progesterone

Are you currently using herbs or supplements to stimulate or simulate estrogen?  Y  N

Are you currently using any other medications? If yes, what? (i.e. Tamoxifen) \_\_\_\_\_

Are you currently using a progesterone cream (applied to:  Breasts only  Rotating body areas)  Y  N

Have you had your ovaries removed? If yes, at what age? \_\_\_\_\_

Have you had your vitamin D levels checked? If yes, at what were the results? \_\_\_\_\_

**Are you experiencing any of the following with your breasts:**  None

A Lump (date found \_\_\_\_\_; by  Self  Doctor. Is it  Hard  Soft  Mobile  Tender)

Pain:  Dull  Sharp  Burning  Stinging  Tenderness  The pain or tenderness changes with my cycle

Thickening  Skin changes ( Color  Texture  Over the lump)

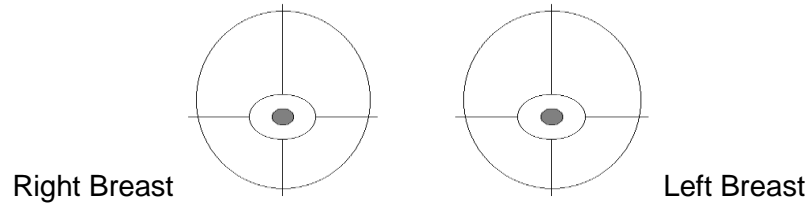
R  L Nipple discharge ( Bloody  Milky  Clear  Through 1 duct  Through multiple ducts)

R  L Nipple retraction  R  L Nipple Changes ( Color  Texture)

Other \_\_\_\_\_

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Place an [ O ] on the diagram in the exact area of the lump, finding on your mammogram, or area being watched, and an [ X ] in the area of pain, tenderness, thickening, or skin changes.




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**Do not write below this line** Risk: H M L  Initial Exam  Re-Exam Tech: \_\_\_\_\_

T = \_\_\_\_\_ F  R  L Nipple retraction  R  L Areola traction toward SLQ SMQ ILQ IMQ  
 R  L Skin surface bulge or dimple SLQ SMQ ILQ IMQ  R  L Skin changes SLQ SMQ ILQ IMQ  
 R  L Nipple Changes ( Color  Texture)  R  L Nipple discharge ( Bloody  Milky  Clear – S M)