

BREAST HEALTH ASSESSMENT

PATIENT INFORMATION

Today's Date _____

Name (Last) _____ First _____ Middle _____

What do you prefer to be called? _____ Birth Date _____ Age _____

Phone (preferred number) _____ Email _____

Height _____ Weight _____ PCP and/or Referring Provider _____

BREAST

Why are you seeing the doctor today? _____

Most recent breast exam by a doctor or nurse _____

Most recent mammogram _____

Have any of your mammograms shown dense breast tissue? Yes No

Any other recent breast imaging studies? _____

Have you ever had:

Abnormal mammogram? No Yes, when _____

Breast biopsy? No Yes, when _____

Breast surgery? No Yes, when _____

Have you had any of the following?

Breast lump Yes No Redness/swelling Yes No

Nipple discharge Yes No Rash/scaling skin/itching Yes No

Nipple retraction Yes No Breast pain Yes No

Skin dimpling or retraction Yes No Other _____

HORMONES

Age at first period _____

Are you: Pre-menopausal Last menstrual period _____

Peri-menopausal Last menstrual period _____

Post-menopausal Age at menopause _____ Natural Surgical

Have you used hormone replacement therapy? Yes No

Age at first use _____ Age at last use _____

Type: Estrogen only Progesterone only Combination estrogen-progesterone

PREGNANCIES

Number of pregnancies _____ Number of live births _____ Age at first live birth _____

Did you breastfeed? No Yes, how long? _____

Name _____

DOB _____

CANCER

Personal history of any cancer? No Yes, type? _____

Radiation therapy to chest? Yes No

History of collagen-vascular disease like lupus, Sjogrens syndrome, scleroderma? Yes No

SOCIAL

How much alcohol do you drink? _____

Do you use any tobacco? Yes No If you quit, when? _____

Marijuana? Yes No

Other drugs? Yes No

MEDICAL HISTORY (check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Aneurysm |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Stroke or TIA (Transient Ischemic Attack) |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Carotid Artery Disease |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Peptic Ulcer Disease | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Heart Valve Disease | <input type="checkbox"/> Colon Polyps | <input type="checkbox"/> Leg pain with walking |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Diverticulosis/Diverticulitis | <input type="checkbox"/> DVT/Blood clots |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Pulmonary Embolism |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bleeding disorder |
| <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Renal Disease or Failure | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Kidney or Urinary Infection | <input type="checkbox"/> Rheumatic disease |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Depression or Anxiety | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Crohn's Disease/ Ulcerative Colitis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> GERD/Heartburn | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> _____ |

ALLERGIES

Allergies to medications _____

MEDICATIONS

List all medications you take regularly (including prescription drugs, vitamins, herbals, and over-the-counter):

- | | |
|----------|-----------|
| 1. _____ | 7. _____ |
| 2. _____ | 8. _____ |
| 3. _____ | 9. _____ |
| 4. _____ | 10. _____ |
| 5. _____ | 11. _____ |
| 6. _____ | 12. _____ |

Name _____ DOB _____

SURGICAL HISTORY (please include approximate date and surgeon/facility)

- 1. _____ 4. _____
- 2. _____ 5. _____
- 3. _____ 6. _____

FAMILY CANCER HISTORY

Please list your family member’s relation to you and their age at cancer diagnosis.*

	Mother’s Side	Father’s Side
Uterine Cancer		
Colon/Rectal Cancer		
Stomach Cancer		
Small Bowel Cancer		
Brain Cancer		
Kidney or Urinary Tract Cancer		
Colon Polyps		
Breast Cancer		
Ovarian Cancer		
Pancreatic Cancer		

Ashkenazi Jewish Decent? Yes No

Have you or your family members ever had genetic testing? No Yes, results? _____

Is there any other cancer in a family member that is not listed above? Please list their relation and age at diagnosis here: _____

Do any other diseases run in your family (for example, heart disease, stroke, bleeding disorders)? _____

* First Degree Relatives = Mother/Father/Sister/Brother/Children

Name _____

DOB _____

Please check if you are CURRENTLY having trouble with any of the following (check all that apply):

GENERAL

- Fever Chills Sweats
- Headache/Migraine
- Decreased Appetite
- Fatigue
- Feeling Poorly (Malaise)
- Weight Loss

EYES

- Blurring
- Double vision (Diplopia)
- Irritation
- Discharge
- Vision loss
- Eye Pain
- Light Sensitivity

EARS/NOSE/THROAT

- Earache
- Ear Discharge
- Ringing of the Ears (Tinnitus)
- Decreased Hearing
- Nasal Congestion
- Nosebleeds
- Sore Throat
- Hoarseness
- Trouble Swallowing

HEART/VASCULAR

- Chest Pains
- Palpitations
- Fainting (Syncope)
- Painful breathing with exercise
- Lightheaded when standing up
- Peripheral Vascular Disease
- Swelling of Arms/Legs

OTHER

GASTROINTESTINAL

- Nausea
- Vomiting
- Diarrhea (6+ loose stools daily)
- Constipation
- Change in bowel habits
- Abdominal Pain
- Black stools (Melena)
- Blood in stool
- Yellow Skin (Jaundice)

GENITOURINARY

- Vaginal Discharge
- Incontinence
- Painful Urination (Dysuria)
- Blood in Urine (Hematuria)
- Urinary Frequency
- No periods (Amenorrhea)
- Abnormal Menstrual Bleeding
- Pelvic Pain

MUSCULOSKELETAL

- Back Pain
- Joint Pain
- Joint Swelling
- Muscle Cramps
- Muscle Weakness
- Stiffness
- Arthritis

NEUROLOGIC

- Transient Paralysis
- Weakness
- Paresthesias (numbness)
- Seizures
- Passing out (Syncope)
- Tremors
- Dizziness (Vertigo)

RESPIRATORY

- Cough
- Painful Breathing (Dyspnea)
- Excessive Sputum
- Spitting up Blood
- Wheezing

SKIN

- Rash
- Itching
- Dryness
- Suspicious Lesions

PSYCHIATRIC

- Depression
- Anxiety
- Memory Loss
- Mental Disturbance
- Suicidal Ideation
- Hallucinations
- Paranoid

ENDOCRINE

- Cold Intolerance
- Heat Intolerance
- Excessive thirst
- Excessive hunger
- Excessive Urine
- Weight Loss

HEME/LYMPHATIC

- Abnormal Bruising
- Bleeding
- Enlarged Lymph Nodes

ALLERGIC/IMMUNOLOGIC

- Itching (Urticaria)
- Hay Fever
- Persistent Infections
- HIV Exposure