PATIENT INFORMATION:

Patient's Name:_____ Today's Date:_____

Patient's Date of Birth:_____ Patient's Age:_____

Race:_____

Breast History Form:

- History of Any Masses? ☐ Yes _____ ☐ No _____
- Previous Breast Biopsy? ☐ Yes _____ How Many Times?_____
  ☐ No _____
  - Results of Biopsy Malignant _____ Benign _____ ADH_____
- History of A Nipple Discharge? ☐ Yes _____ ☐ No _____
- Do You Take Hormones? ☐ Yes _____ ☐ No _____ Name _____
- Do You Take Birth Control Pills? ☐ Yes _____ ☐ No _____ Name _____
- Do You Still Menstruate? ☐ Yes _____ ☐ No _____
- Any History of Radiation Treatment? ☐ Yes _____ ☐ No _____
- How Many Pregnancies? _____
- How Many Children? #_____ Ages____/____/____/____/____/____/____/____
  Your Age When You had your 1st Child _____
- Age of 1St Menstrual Period? _____
- Date of Last Menstrual Period? _____
- Age of Menopause? _____

Family History: **If Yes, WHOM? Please List**

- Breast Cancer? ☐ Yes ☐ No_____
- Ovarian Cancer? ☐ Yes ☐ No _____
- Uterine Cancer? ☐ Yes ☐ No _____
- Colon Cancer? ☐Yes ☐ No _____