ENGLEWOOD HOSPITAL & MEDICAL BREAST CARE CENTER (History & Exam Form) Today's Date__/__/____

Patient Name: _____ Date of Birth: ____/___/_____ Age:_____

Address: _____ Phone (home)_____(cell)_____(W)_____

Have you had previous mammograms? Yes/No Where: _____ Date: _____

Have you had breast ultrasound or MRI? Yes/No Where: _____ Date: _____

To whom would you like your report sent to? (Provide address/phone/fax)

Primary Care Provider: _____

GYN: _____

MENSTRUATION HISTORY:

- *Date of last period:*_____
- *Age at first period:*_____
- *Age at menopause*_____
- *Age when had first child*_____
- *Age at hysterectomy*_____
- *Do you have children? Yes/No*

PRESENT AND FERTILITY HISTORY:

- *Presently pregnant? Yes/No*
- *Breastfeeding: Yes/No*
- *On birth control pills? Yes/No*
- *On infertility drugs? Yes/No*
- *On hormone replacement therapy? Yes/No How long? _____*

RECENT BREAST CHANGES:

- Lump: right/left how long?_____
- Thickening: right/left how long?_____
- Swelling: right/left how long?_____
- Tenderness: right/left how long?_____
- Pain: right/left how long?_____
- Nipple inversion: right/left how long?_____
- Nipple discharge: right/left how long?_____

DO YOU HAVE A PERSONAL OR FAMILY HISTORY OF CANCER: please indicate age at diagnosis:

BREAST CANCER Self_____ Age at diagnosis: _____

- Mother: _____Age: _____ Father: _____Age:_____
- Grandmother: _____ Paternal/Maternal Age(s): _____
- Sister(s)_____Age(s):_____
- Aunt(s)_____ Paternal/Maternal Age(s): _____

Ovarian Cancer: Who:_____

Cervical or uterine Cancer: Who_____ Colon Cancer: Who_____

Thyroid Cancer: Who_____ Prostate Cancer: Who_____

HAVE YOU HAD ANY OF THE FOLLOWING TREATMENTS FOR BREAST CANCER:

Partial mastectomy: Right/Left When_____

Mastectomy: Right/Left When_____

Did you have a tram flap or implant _____

Radiation: Yes/No_____ Chemotherapy: Yes/No_____

Tamoxifen: Yes/No_____ Other: Yes/No_____

HAVE YOU HAD ANY BREAST SURGERY (BENIGN):

Excision and/or Open biopsy: Right/left When:_____ Results:_____

Mammotome or stereotactic biopsy: Right/left When:_____ Results:_____

Fine Needle Aspiration: Right/left When:_____ Results:_____

Core Biopsy: Right/left When:_____ Results:_____

Breast Reduction/lift: Right/left Year:_____ Implants- Saline/Silicone: Right/left year:_____

BREAST EXAM:

Do you perform self-breast exam (SBE)? Yes/No Would you like instruction on Performing SBE? Yes/No

When was your last breast exam by your health care provider?_____

May we leave a message on your answering machine regarding your results or follow-up? Yes/No

May we leave a message with a third party? Yes/No (2000.10) Rev 5/24/04