Name:_____Date of Birth:_____Todays Date:_____

BREAST CLINICAL HISTORY AND RISK EVALUATION FORM

Briefly describe the reason for your visit today:_____
_____
_____

GYNECOLOGIC HISTORY

At what age did you get your first period? _____
When was your last menstrual period? _____
Have you been through menopause? ☐ Yes (age : _____) ☐ No
Have you ever been pregnant? ☐ Yes (# of pregnancies _____) ☐ No
If yes, how many children do you have? _____
How old were you when your first child was born? _____
Did you Breast Feed? ☐ Yes (# of months _____) ☐ No

HORMONE HISTORY

Have you ever taken Birth Control pills? ☐ Yes (# of years _____) ☐ No
Are you currently taking Birth Control pills? ☐ Yes ☐ No
Have you ever taken hormone replacement therapy? ☐Yes (# of years _____) ☐ No
Are you on hormone replacement therapy now? ☐ Yes ☐ No
Have you ever been treated for infertility? ☐ Yes ☐ No

BREAST HISTORY

Have you ever had a breast biopsy? ☐ Yes (dates:_____) ☐ No
Have you ever been treated with radiation to your chest? _____
Do you have any of the following? (Please circle)

Breast Masses	Breast Pain	Skin Changes
Nipple Discharge	Nipple Changes	Lumps in underarms

Are you a BRCA Carrier? ☐ Yes ☐ No ☐Unknown
Do you have any Ashkenazi Jewish ancestry? ☐ Yes ☐ No

PAST MEDICAL HISTORY

Please list your current medical problems	Please list any surgeries you have had
1. _____	1._____
2. _____	2._____
3. _____	3._____
4. _____	4._____

ALLERGIES

Are you allergic to any medications? ☐ Yes ☐ No
Which ones? _____
Describe Reaction: _____

MEDICATIONS

Please list current medications

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Please list all vitamins and supplements you are taking: _____

_____

SOCIAL HISTORY

Do you smoke? ☐ Yes (# packs per day _____ # of years: _____) ☐ No

Do you drink alcohol? ☐ Yes (# of drinks per day _____) ☐ No

What is your current occupation? _____

FAMILY HISTORY

Do you have a family history of Breast Cancer? ☐ Yes ☐ No (who:_____)

Do you have a family history of Ovarian Cancer? ☐ Yes ☐ No (who:_____)

Describe any medical conditions that run in your family:

Mother_____

Father_____

Sister_____

Brother_____

Daughter_____

Son_____

YOUR HISTORY

Have you previously been treated for any of the following? (Please circle)

Chest Pain	Pneumonia	Cirrhosis
Heart Attack	Peptic Ulcer Disease	Kidney Disease
High Blood Pressure	Nausea/Vomiting	Kidney/Bladder infection
High Cholesterol	Heartburn	Kidney stones
Heart Valvular Problems	Diverticulitis	Cancer of any kind
Strokes	Constipation	Bleeding disorders
Shortness of Breath	Diarrhea	H/o Blood transfusions
Congestive Heart Failure	IBD	Diabetes
Emphysema	Liver Disease	Thyroid Problems
Asthma	Hepatits	Scleroderma
Lupus	Arthritis	Psychiatric Disorders
Anesthesia Complications		