BREAST HISTORY FORM

PLEASE BRING FORM WITH YOU TO YOUR APPOINTMENT

Methodist Mobile Mammography

Name _____ Date of Birth _____/_____/_____

Phone/Cell Phone _____ Today's Date _____/_____/_____

Weight _____ lbs. Height _____ ft _____ in Ethnicity _____

Have **YOU** ever had breast cancer? Y/N _____ Left/Right _____ At Age _____

Lumpectomy/Mastectomy (Circle One) Chemo Y/N _____ Radiation Y/N _____

Have **YOU** ever had any type of cancer? Type _____ At Age _____

Are you Ashkenazi Jewish? Y/N _____

DOES ANYONE IN YOUR IMMEDIATE FAMILY HAVE A HISTORY OF CANCER?

Relation	Cancer Type	At Age	Maternal/Paternal
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever had genetic testing for breast cancer?

Gene Type _____ Outcome _____

Family member genetic testing Relative _____

Gene Type _____ Outcome _____

Age at 1st period _____ Number of live births _____ First pregnancy age _____

Last menstrual period _____ Menopause age _____ Hysterectomy age _____

Right/Left ovary removed at age _____

Methodist Mobile Mammography

Name _____ Date of Birth _____/_____/_____

BREAST SURGERY/BIOPSY HISTORY

Implants Y/N _____ Right/Left/Both _____ Year _____

Breast Reduction Y/N _____ Year _____

Needle/Core Biopsy Right _____ Left _____ Year _____ Outcome _____

Excisional Biopsy Right _____ Left _____ Year _____ Outcome _____

HORMONE HISTORY

	Currently Using	Age at First Use	Age at Last Use	Duration of Use
Birth Control Pills	_____	_____	_____	_____
Estrogen	_____	_____	_____	_____
Progesterone	_____	_____	_____	_____
Tamoxifen	_____	_____	_____	_____
Raloxifene	_____	_____	_____	_____

Are you having any NEW BREAST symptoms since your last mammogram? Yes/No _____

If yes, please explain _____

_____

_____

For MD office use only:

Return to clinic next year for:

Screening Mammogram _____

Diagnostic Mammogram _____

3 month f/u _____ 6 month f/u _____ 9 month f/u _____

Dense _____ Not Dense _____

BACK