

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's 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                   | Hepatitis            | Scleroderma              |
| Lupus                    | Arthritis            | Psychiatric Disorders    |
| Anesthesia Complications |                      |                          |