Breast History and Risk Assessment

Name: ______________________________ Date: ____________

Date of Birth: ____________ Age: __________ r w b a o

Personal Breast History

Have you ever had a mammogram? Y N What years? ____________

Have you ever had an ultrasound? Y N What years? ____________

Have you ever had an MRI? Y N What years? ____________

Have you ever had a breast biopsy? Y N When? __________ Results? __________

Have you ever had a breast cyst aspirated: Y N When? ____________

Do you have breast pain? Y N Do you have a lump that you can feel? Y N

Do you have regular periods? Y N Do you have a lump that your doctor can feel? Y N

Do you have a nipple discharge? Y N Have you ever had breast cancer Y N

Family History: *Have **you** or any of your family members ever been diagnosed with any of the following?*

Breast Cancer Y N What relation? __________ Age at diagnosis ________ Present Age ________

Ovarian Cancer Y N What relation? __________ Age at diagnosis ________ Present Age ________

Endometrial Cancer Y N What relation? __________ Age at diagnosis ________ Present Age ________

Reproductive History:

Age at first period ____________ Age at menopause __________

Have you ever been pregnant? Y N If not, skip down to the *Hormonal Drug History* Section

Please fill in the length of each pregnancy by the # of weeks: (a full-term pregnancy is 40 weeks)
Example: A first pregnancy that ended with a live birth at full-term would be logged as 40 in the 1st pregnancy column beside live birth.
A second pregnancy that ended with a miscarriage at 12 weeks would be logged as 12 in 2nd pregnancy column beside miscarriage.

Pregnancy	1st	2nd	3rd	4th	5th	6th	7th	8th
Age at the end of each pregnancy								
Live Birth								
Still Birth								
Miscarriage								
Abortion								
Ectopic Pregnancy								
Multiple Birth								
How many weeks did you breastfeed?								

Hormonal Drug History:

Have you ever used a hormone replacement? (e.g., estrogen, progesterone, Provera, Premarin) Y N

Name: ______________ How long? __________ Age when started: __________

Have you ever used fertility drugs? (e.g., Clomid, Pergonal) Y N Age when started: __________

Name: ______________ How long used: __________

Contraceptive History: Have you ever used any of the following?

Birth Control Pills? Y N Age when started:________ How long used? ________ Age when ended use: ________

Name: ______________

Contraceptive injectable and/or device? (e.g., Norplant, Depoprovera, IUD) Y N Age when started: __________

Name: ______________ How long used: __________

Radiation History: Have you ever received a high level of exposure to radiation to your chest wall (e.g., Hodgkin's therapy, repeated fluroscopies) Y N

Tobacco History: Have you ever smoked cigarettes? Y N Age started: ______ Age quit: ______ Packs per day: ______

Alcohol History: Do you drink alcohol? Y N How many drinks per week? ______