

Today's Date _____

Name _____ DOB _____ Age _____

1. Previous breast masses? Yes _____ No _____
2. Hormone use: (i.e.) Provera _____ Premarin _____
Birth Control Pills _____
3. Family history of breast cancer? Yes _____ No _____
Mother _____
Sister _____
Cousin _____
Aunt _____
4. Previous breast biopsies? Yes _____ No _____
When? _____
Which breast? _____
5. Previous mammograms? Yes _____ No _____
When? _____ Where? _____
6. Onset of Menses?
(first menstrual period) Year _____ Age _____
7. Menopause
("change in life") (if applicable) Year _____
8. Last menstrual period? Date _____
9. Hysterectomy:
If yes, were the ovaries removed? Yes _____ No _____

10. Do you have children? Yes _____ No _____
Were your children breast fed? Yes _____ No _____
11. What is the age of your oldest child? _____
12. Are you having any nipple discharge? _____
13. Do you practice self-breast Examinations? Yes _____ No _____
Monthly? _____
Occasionally? _____