Name: _____
Age: _____
PCP: _____
Other MD/NP: _____
Date: _____

VS: HT _____ **WT:** _____ **BMI:** _____ **T:** _____ **P:** _____ **R:** _____ **BP:** _____ **LMP:** ___/___/___

REASON FOR TODAY'S VISIT:

Please tell us when you last had the following and indicate results normal or abnormal:
Breast Imaging (50-75):

Type:

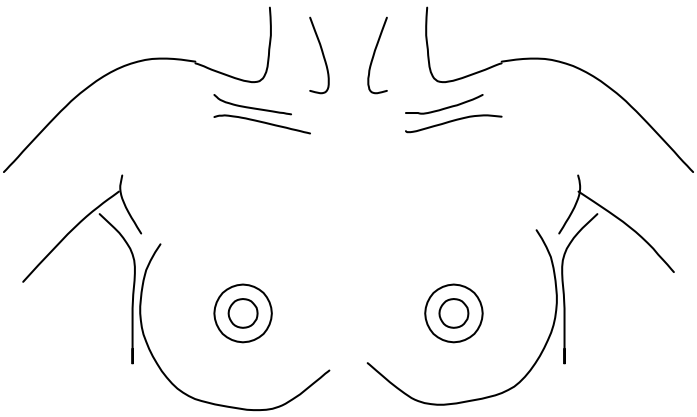
Colonoscopy (50-75):

Flu Shot:

Pneumonia Vaccine (>65):

Falls in Past 6mo (>65):

NOTES:



Name: _____
Age: _____
Referring MD/NP: _____
Other MD/NP: _____
Date: _____

REASON FOR TODAY'S VISIT: ***(Please check all that apply)***

	CURRENT	PRIOR		CURRENT	PRIOR
Breast lump (you/doctor can feel)	[ ]	[ ]	Nipple Symptoms	[ ]	[ ]
Abnormal mammogram/ultrasound/MRI	[ ]	[ ]	Breast Pain	[ ]	[ ]
Family history of breast cancer	[ ]	[ ]	Other	[ ]	[ ]

MENSTRUAL HISTORY: Do you still have menstrual periods? [ ] YES [ ] NO

Date your last menstrual period began: (LMP) ___/___/___

How old were you when you had your first period? _____

MENOPAUSE: Have you gone through menopause? [ ] YES [ ] NO

If yes, age you stopped having periods: _____

Are you currently experiencing menopausal symptoms? [ ] YES [ ] NO

Please describe: _____

Did you have a hysterectomy (removal of the uterus)? [ ] YES [ ] NO

If yes, please provide the reason _____

Age: _____ Date of surgery ___/___/___

Were your ovaries removed? [ ] YES [ ] NO

[ ] ONE [ ] BOTH [ ] UNKNOWN

If yes, please provide the reason _____

PREGNANCY & NURSING: Have you ever been pregnant? [ ] YES [ ] NO

How many pregnancies? _____ How many children? _____

Did you Breastfeed? [ ] YES [ ] NO

If yes, for how long? _____

How old were you when your first child was born? _____

Please list any multiple births: _____

HORMON MEDICATION USE: Have you ever used…

Birth Control Pills, Patch or Implant? [ ] YES [ ] NO

What type(s)? _____

Are you using any now? [ ] YES [ ] NO

Total years of use: _____

Infertility medicine? [ ] YES [ ] NO

Please describe type(s) and number of cycles (duration):

_____

Hormone Replacement Therapy? **[ ] YES** **[ ] NO**

What type(s): _____

Are you currently taking HRT? **[ ] YES** **[ ] NO**

Total years of use _____ How long ago did you stop? _____

PAST MEDICAL HISTORY: Please list all medical conditions that you have or have had in the past.

[ ] I have no significant medical problems

PAST SURGICAL HISTORY: Please approximate date and type of surgery:

[ ] I have never had surgery

PRIOR BREAST BIOPSIES

Have you had any breast biopsies? [ ] YES [ ] NO

If yes, what type? [ ] Surgical [ ] Core Needle [ ] Fine Needle Aspiration

Year and side(s):_____

Reason for the biopsy: _____

Result: _____

SOCIAL HISTORY: Please use the back of the page if you need more space

	NEVER	PRIOR	CURRENT	AMOUNT	HOW LONG?
Cigarettes/Cigars					
Alcohol					
Other (type?)					

Occupation: _____ Marital Status: _____

Who do you live with? _____

FAMILY HISTORY: Please list all relatives who have had any type of cancer:

Relative	Mother's or Father's Side	Age at Diagnosis	Type of Cancer

[ ] NONE KNOWN

Please list any other diseases that run in the family, such as heart disease or diabetes:

[ ] NONE KNOWN

Please include any other history which you think is important:

Patient Signature: _____ Date: ____/_____/_____

As a courtesy, we will forward a letter to your PCP and 1 other physician.

Please list physician(s) here: _____

(name & address)

_____

(name & address)