

Name: _____

Date of Birth: _____

Age: _____

Breast History

Please answer all questions below.

1. Gail Model Information:

Age menstruation began: _____

Age at first live birth: _____

Ethnic Background: _____

Ashkenazi Ancestry? _____

2. Ovarian Cancer:

Have you had ovarian cancer? YES NO

Family history of ovarian cancer? If yes, who? _____

3. Lymphoma/Hodgkins:

Did you have radiation treatment to your chest between 10-30 years of age? YES NO

4. Other Personal History of Cancers?

Cervical? YES NO

Uterine? YES NO

Thyroid? YES NO

Other? _____

5. Hormones:

Are you currently taking hormones, estrogen or progesterone? YES NO

6. Tamoxifen or Arimedex:

Currently or ever taken? YES NO

7. BRCA Testing:

Have you been tested? YES NO

If yes, are you positive? YES NO

Relatives BRCA Positive? _____

8. Family History of Breast Cancer?

List relationship & age of diagnosis:

9. Prior Mammograms?

If so, when/where? _____

Did you bring your films & reports today? _____

10. Benign Breast Surgeries:

Cyst Aspiration? Right Left # _____

Needle Core Biopsy? Right Left # _____

Excisional Biopsy? Right Left # _____

Diagnosis of ADH or LCIS? YES NO

11. Other Breast Surgeries:

Reduction? YES NO When? _____

Implants? YES NO When? _____

If yes, Silicone Saline

Have you had your implants removed? YES NO

12. Breast Cancer Survivors:

Lumpectomy? Right Left

Mastectomy? Right Left

Radiation Therapy? Right Left

Chemotherapy? YES NO

Indicate any current problems:

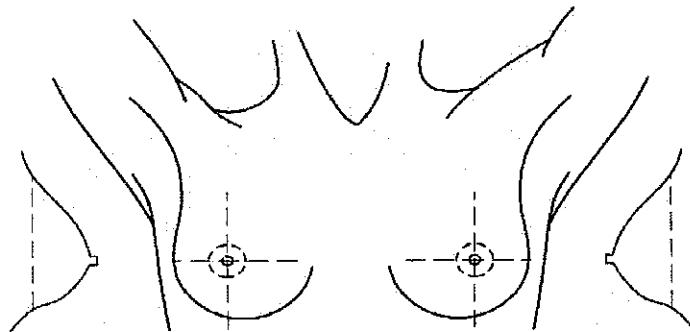
Lump in breast? Right Left

Nipple discharge? Right Left

Pain/soreness? Right Left

Other concerns? _____

Indicate the location(s) of any current problems:



Tech Notes (For office use):

I attest that the answers I have provided to questions on this form are correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions

Signature (Parent or Guardian)

Date Signed: _____