

# Initial Breast Health History

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Email: \_\_\_\_\_

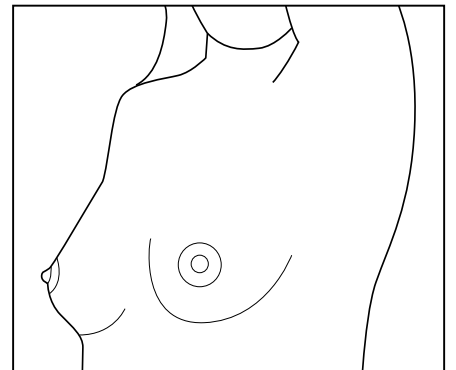
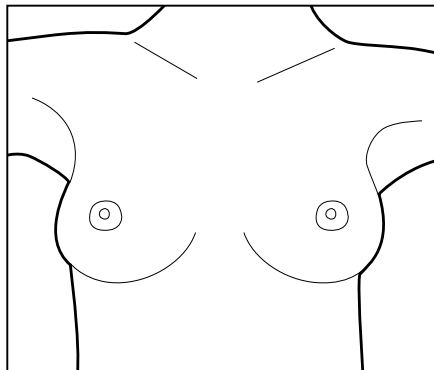
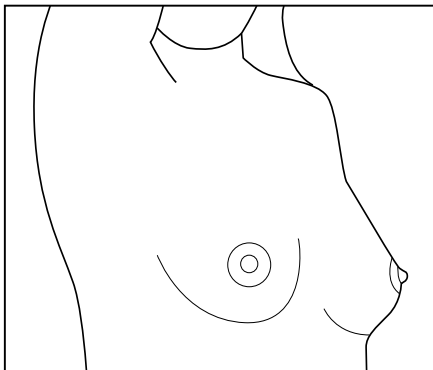
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Daytime Phone #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex:  F  M

Describe any current breast concerns such as lumps, pain, or abnormal examination findings:

\_\_\_\_\_  
\_\_\_\_\_

**MARK THE AREA OF ANY NEW CONCERN ON THE DIAGRAM:**



\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Last Physical Breast Examination: Date \_\_\_\_\_

Results:  Normal  Other \_\_\_\_\_

Mammogram: Date \_\_\_\_\_

Results:  Normal  Other \_\_\_\_\_

Other Breast Tests (Ultrasound, MRI or Biopsy etc.) List test, date and results \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**COMPLETE ALL THAT APPLY:**

Diagnosed with breast cancer: Date of diagnosis \_\_\_\_\_,  
Location of cancer and type, if known \_\_\_\_\_

Lumpectomy  Mastectomy  Reconstruction: Date and details of procedure:  
\_\_\_\_\_  
\_\_\_\_\_

Radiation treatment: Date last performed: \_\_\_\_\_

Chemotherapy: Since: \_\_\_\_\_

Other treatment \_\_\_\_\_

Fibrocystic breasts  Y  N, Cystic breasts  Y  N Other breast conditions  
\_\_\_\_\_

Breast surgery other than for cancer (benign lumpectomy, implants, reductions, etc.).  
Date and procedure: \_\_\_\_\_

Past injury to the breasts: Provide date, description and location \_\_\_\_\_  
\_\_\_\_\_

Birth control pills use: Duration: \_\_\_\_\_ Currently taking:  Y  N

Prescription hormone replacement use including bioidentical:  
Duration: \_\_\_\_\_ Currently taking:  Y  N  
List types: \_\_\_\_\_  
\_\_\_\_\_

Non-prescription hormonal cream use and/or supplements to balance female hormones or thyroid.  
Currently taking:  Y  N  
List types: \_\_\_\_\_

Other medications: List types: \_\_\_\_\_  
\_\_\_\_\_

Breast feeding: Currently  Y  N, Number of children nursed for over 1 month: \_\_\_\_\_

Pregnant: If not, current cycle day (# of days since 1<sup>st</sup> day of period) \_\_\_\_\_

Menopause: Experiencing symptoms of menopause or perimenopause:  Y  N  
Age of last menses, if it has stopped: \_\_\_\_\_

Both (not one) ovaries removed:  Y  N, Age (or ages) of removal: \_\_\_\_\_

Family history of breast cancer: List family member(s): \_\_\_\_\_  
\_\_\_\_\_