HISTORY OF SYMPTOMS for the BREAST

Name _____ Date _____

Date of Birth _____ Age _____

1. Date of last breast examination _____ Physician _____
2. What age did your menstrual period begin? _____ Do you take birth control pills? ___ Do you smoke? ___
3. How many pregnancies have you had? _____ Live births? _____
4. Have you gone thru menopause? No _ Yes __ Are you on hormones? No _ Yes __
5. When was your last mammogram? _____ Was it Normal or Abnormal? _____
6. Is there a family history of breast cancer? No _ Yes __ Who? _____
7. Have you ever had a breast lump or biopsy? No _ Yes __ When? _____
8. Have you had a BRCA test? No _ Yes __ **When?** _____ **Was** it positive? No _ Yes __
9. Have you ever been diagnosed with breast cancer?
   No _ Yes __ Left breast __ When _____ Right breast ___ When _____
10. Have you had radiation? No _ Yes __ Left breast __ When _____ Right breast ___ When _____
11. Have you had chemotherapy? No _ Yes __ Left breast __ When _____ Right breast ___ When _____
12. Have you had a lumpectomy? No _ Yes __ Left breast __ When _____ Right breast ___ When _____
13. Have you had a mastectomy? No _ Yes __ Left breast __ When _____ Right breast ___ When _____
14. Do you have a lumpectomy scheduled? No __ Yes __ When _____
15. Do you have a mastectomy scheduled? No __ Yes __ When _____
16. What Physician do you have this scheduled with? _____

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17. Have you had breast implants in the past? No _ Yes __
18. Do you now have implants? No _ Yes __ Type? **saline** **silicone** **polyurethane** How many CC's? _____
19. What size bra do you wear now? _____ What size would you like to wear? _____

The above information is accurate and true to the best of my knowledge. I have not left out pertinent information nor given inaccurate information.

Patient signature _____ Date _____