LINCOLN SURGICAL ASSOCIATES, LTD

1414 Cross Street, Suite 330
Shiloh, IL 62269
618.277.7400 **Phone**
618.277.7422 **Fax**

Breast History Form

Name: _____ Date: ____/____/____
Last First Middle Initial Month Day Year

DOB:____/____/____ Height _____ Weight _____ lbs. Date of last menstrual cycle____/____/____

REASON FOR VISIT: *(Check all that apply.)*

❑ Skin Changes ❑ Lump(s) ❑ Breast Pain
❑ Nipple Discharge ❑ Abnormal Mammogram/Ultrasound
❑ Other *If other, please describe:* _____

PREVIOUS BREAST BIOPSY: How Many? _____

Date/Result of Each: _____

PREVIOUS HISTORY: *(Check all that apply.)*

❑ Breast Cancer ❑ Ductal Carcinoma in Situ ❑ Lobular Carcinoma in Situ
❑ Atypical Ductal Hyperplasia ❑ History of Radiation Therapy to Chest

How many children? _____ Did you breastfeed? ❑ Yes ❑ No

Age at first pregnancy: _____ Age when you started having menstrual periods (menarche): _____

Age when you reached menopause (if applicable): _____

Do you take oral contraceptives? ❑ No ❑ Yes If yes, how many years? _____

Do you take hormone replacement therapy? ❑ Yes ❑ No If yes, how many years? _____

FIRST-DEGREE FEMALE RELATIVES: *(ex. mother, sister, daughter) with history of breast cancer and/or ovarian cancer*

Family history of breast cancer? ❑ Yes ❑ No If yes, please fill section below. *(Check all that apply.)*

Name / Age (Current) / Relationship / Age of Diagnosis	Breast Cancer?	Ovarian Cancer?
1)	❑ Yes ❑ No	❑ Yes ❑ No
2)	❑ Yes ❑ No	❑ Yes ❑ No
3)	❑ Yes ❑ No	❑ Yes ❑ No
4)	❑ Yes ❑ No	❑ Yes ❑ No
5)	❑ Yes ❑ No	❑ Yes ❑ No
6)	❑ Yes ❑ No	❑ Yes ❑ No

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Patient Name:_____ DOB:____/____/____ Date:____/____/____

ADDITIONAL NOTES: Write any notable information not included in the form.