

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)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No



LINCOLN
SURGICAL
ASSOCIATES, LTD

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

Breast History Form

Patient Name: _____ DOB: ___ / ___ / ___ Date: ___ / ___ / ___

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