

## BREAST HEALTH HISTORY

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code \_\_\_\_\_

Home Tel: \_\_\_\_\_ Work Tel: \_\_\_\_\_ E-mail \_\_\_\_\_

Occupation: \_\_\_\_\_

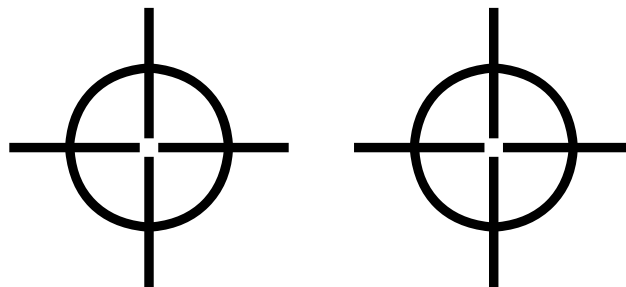
Marital Status: S M D W SEP. Number of Children: \_\_\_\_\_ Referred By: \_\_\_\_\_

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- Y  N Do you have a family history of breast cancer?  
 Self  Mother  Maternal Grandmother  Sister  Daughter  None
- Y  N Do you have any diagnosed breast conditions?  
 None  Fibrocystic  Cystic  Other \_\_\_\_\_
- Y  N Have you previously had a thermogram? Date of most recent \_\_\_\_\_  
Was it:  Normal  Abnormal  Suspicious  Being watched  R  L Breast
- Y  N Have you had a mammogram? Date of most recent \_\_\_\_\_  
Was it:  Normal  Abnormal  Suspicious  Being watched  R  L Breast
- Y  N Have you had a breast ultrasound? Date of most recent \_\_\_\_\_  
Was it:  Normal  Abnormal  Suspicious  Being watched  R  L Breast
- Y  N Have you had a breast exam by a doctor? Date of most recent \_\_\_\_\_  
Was it:  Normal  Lump Found  R  L Breast
- Y  N Any breast biopsies?  
When and what type (i.e. needle, core)? \_\_\_\_\_  R  L Breast
- Y  N Any breast surgeries? When and what was done? \_\_\_\_\_  R  L Breast
- Y  N Have you had a mastectomy? When? \_\_\_\_\_  R  L Breast
- Y  N Have you had radiation? When was it last performed? \_\_\_\_\_  R  L Breast
- Y  N Have your had your ovaries removed? At what age? \_\_\_\_\_
- Y  N Do you have children. At what age was your first full term pregnancy? \_\_\_\_\_
- Y  N Did you nurse for at least three months? How long \_\_\_\_\_
- Y  N Are you currently nursing?
- Y  N Are you currently pregnant?
- Y  N Are you currently taking birth control pills?  
At what age did you start? \_\_\_\_\_ for how many years? \_\_\_\_\_
- Y  N Are you in menopause? At what age did it begin? \_\_\_\_\_

- Y  N Have you ever taken synthetic hormone replacement (ex. Premarin, Provera)?  
How many years taken? \_\_\_\_\_
- Y  N Are you currently using natural progesterone cream?  
Applied to  Breasts only  Rotating body areas
- Y  N Are you currently using herbals, homeopathic medicines, or supplements to stimulate or simulate estrogen? Explain \_\_\_\_\_
- Y  N Do you feel that you are overweight? How many pounds overweight? \_\_\_\_\_
- Are you experiencing any of the following with your breasts?**
- Y  N A lump. Date found: \_\_\_\_\_ by  Self  Doctor  
It is:  Hard  Soft  Mobile  Tender
- Y  N Pain  
It is  Dull  Sharp  Burning  Stinging  Tender  Changes with my cycle
- Y  N Thickening
- Y  N Skin changes ( Color  Texture  Over the lump)
- Y  N Nipple discharge  R  L Breast  
It is  Bloody  Milky  Through one duct  through multiple ducts
- Y  N Nipple retraction  R  L Breast
- Y  N Nipple changes  R  L Breast  
Change in:  Color  Texture
- Y  N Other \_\_\_\_\_

Place an [O] on the diagram in the exact area of the lump, finding on your mammogram, or area being watched, and an [X] in the area of pain, tenderness, thickening, or skin changes.



RIGHT BREAST

LEFT BREAST

Please note any other concerns/issues you may have: \_\_\_\_\_

# General Health Information

Y  N Do you have any medical complaints or conditions? Please explain \_\_\_\_\_  
\_\_\_\_\_

Y  N Are you currently taking any medications? Please list \_\_\_\_\_  
\_\_\_\_\_

**Please circle all of the following conditions which you have had:**

- |             |             |                  |                             |                 |                |
|-------------|-------------|------------------|-----------------------------|-----------------|----------------|
| Abscesses   | Depression  | Heart Disease    | Mononucleosis               | Rheumatic Fever | Syphilis       |
| Addiction   | Diabetes    | Hepatitis        | Mumps                       | Rubella         | Tonsillitis    |
| Allergies   | Emphysema   | Herpes Genitalia | Parasites                   | Scarlet Fever   | Tuberculosis   |
| Amnesia     | Epilepsy    | Influenza        | Pelvic Inflammatory Disease | Sexual Abuse    | Typhoid Fever  |
| Arthritis   | Gall Stones | Kidney Disease   | Peritonitis                 | Skin Disease    | Venereal Warts |
| Asthma      | Goiter      | Leukemia         | Pleurisy                    | Strep Throat    | Warts          |
| Cancer      | Gonorrhea   | Malaria          | Pneumonia                   | Sinusitis       | Whooping Cough |
| Chicken Pox | Gout        | Measles          | Prostatitis                 | Sunstroke       | Worms          |
| Cold Sores  | Hay Fever   | Miscarriage      |                             | Stroke          | Yellow Fever   |
| Other _____ |             |                  |                             |                 |                |

Y  N Are there any of the preceding conditions after which you have never been totally well again, or which have been more severe than usual? Explain? \_\_\_\_\_

Y  N Have you had any operations? Which \_\_\_\_\_

Y  N Have you lost any weight recently? How many pounds? \_\_\_\_\_

Y  N Do you exercise? How often? \_\_\_\_\_

Y  N Have you had any major injuries? Explain \_\_\_\_\_

Y  N Are you taking any of the following substances? How much?  
Tobacco: \_\_\_\_\_ Alcohol: \_\_\_\_\_  
Coffee: \_\_\_\_\_ "Recreational Drugs" \_\_\_\_\_

Y  N Have any of the following ailments affected your relatives?  
Alcoholism    Asthma    Diabetes    Gout    Mental Illness    Skin Disease  
Allergies    Cancer    Epilepsy    Hay Fever    Paralysis    Syphilis  
Arthritis    Depression    Gonorrhea    Heart Disease    Pneumonia    Tuberculosis

FAMILY HISTORY	Age if Alive	Age at Death	AILMENTS
Mother:			
Father:			
Brothers:			
Sisters:			
Children:			
Maternal Grandmother:			
Maternal Grandfather:			
Paternal Grandmother:			
Paternal Grandfather:			