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BOARD CERTIFIED
GENERAL, VASCULAR, AND LAPAROSCOPIC SURGERY

BREAST HEALTH HISTORY FORM

Patient Name: ____ Today's Date: ______________________

Reason for today's visit: ____

How old were you at the onset of your first menstrual period? _________
How old were you when you had your last menstrual period? __________
or What was the date of menopause? ___________________________
or What was the date of your hysterectomy? ___________________ Were ovaries removed? ☐ Yes ☐ No

Have you ever taken contraceptives? ☐ Yes ☐ No
Name of drug: ______________________________________ How long did you take it? ___________________
Have you ever taken fertility medications? ☐ Yes ☐ No
Name of drug: ______________________________________ How long did you take it? ___________________
Have you ever taken Hormone Replacement Therapy? ☐ Yes ☐ No
Name of drug: ______________________________________ How long did you take it? ___________________

Do you have children? ☐ Yes ☐ No If yes, how many? ________________
Number of pregnancies: _____________ Age at first pregnancy? ___________
Did you breastfeed? ☐ Yes ☐ No For how long? ___________________

Have you or anyone in your family ever had breast cancer? ☐ Yes ☐ No
Relationship: ______________________________________ Age: _________
Any family history of Breast, Colon, or Ovarian cancer? ☐ Yes ☐ No
Relationship: ______________________________________ Age: _________

Do you perform monthly self-breast exams? ☐ Yes ☐ No
Have you ever had a breast biopsy or surgery? ☐ Yes ☐ No
Have you ever experienced any of the following?
☐ Lump/Mass ☐ Pain
☐ Nipple discharge ☐ Trauma
☐ Skin changes ☐ Infection

Have you had previous breast imaging (mammogram, ultrasound, MRI)? ☐ Yes ☐ No