



BREAST HISTORY

Office Use Only:
 Gail Score _____
 5 YR Risk: _____
 Lifetime Risk: _____

Name: _____

Date of birth: _____ Age: _____ Referring Physician: _____

RACE/ETHNICITY <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Ashkenazi Jewish Heritage <input type="checkbox"/> American Indian or AK Native <input type="checkbox"/> Asian or Pacific Islander	CURRENT BREAST PROBLEMS <input type="checkbox"/> NONE <input type="checkbox"/> Lump <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Tenderness/Pain <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Nipple Secretion <input type="checkbox"/> Right <input type="checkbox"/> Left Color _____
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PERSONAL HISTORY Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Last clinical breast exam: _____ Date of last menstrual period: _____ Age of first period: _____ Age of first pregnancy: _____ Number of births: _____ Are you currently using hormones <input type="checkbox"/> Yes <input type="checkbox"/> No Are you currently using contraceptives <input type="checkbox"/> Yes <input type="checkbox"/> No History of Hodgkin's Lymphoma <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, radiation treatment <input type="checkbox"/> Yes <input type="checkbox"/> No Age diagnosed _____	PREVIOUS MAMMOGRAMS <input type="checkbox"/> NONE Date of last mammogram: _____ Where performed: _____
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BREAST IMPLANTS <input type="checkbox"/> Yes <input type="checkbox"/> No

PREVIOUS GAMMAGRAM OR BREAST MRI <input type="checkbox"/> NONE Date of last GAMMA or breast MRI: _____ Where performed: _____
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RISK FACTORS
 If adopted do you know natural family history? Yes No N/A
 Have you had breast or ovarian cancer? Yes No If yes, specify: _____

Family history of breast and/or ovarian cancer ONLY :

	Current Age or Age Deceased	Age Diagnosed	Breast Cancer	Ovarian Cancer	Deceased		Current Age or Age Deceased	Age Diagnosed	Breast Cancer	Deceased
<input type="checkbox"/> NONE										
<input type="checkbox"/> Mother	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Father	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sister	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Brother	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Daughter	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Son	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Grandmother	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Grandfather	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Aunt	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Uncle	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cousin	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

(1st Degree)

Have you or a family member been tested for the breast cancer gene (BRCA 1 or BRCA2)? Yes No

BREAST SURGERY OR BIOPSY

<input type="checkbox"/> NONE							
<input type="checkbox"/> Biopsy	<input type="checkbox"/> Right	<input type="checkbox"/> Left	Date _____	Positive	Negative	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lumpectomy (benign)	<input type="checkbox"/> Right	<input type="checkbox"/> Left	Date _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lumpectomy (cancer)	<input type="checkbox"/> Right	<input type="checkbox"/> Left	Date _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lumpectomy (w/radiation)	<input type="checkbox"/> Right	<input type="checkbox"/> Left	Date _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Mastectomy	<input type="checkbox"/> Right	<input type="checkbox"/> Left	Date _____				
<input type="checkbox"/> Reduction	<input type="checkbox"/> Right	<input type="checkbox"/> Left	Date _____				

_____ PATIENT SIGNATURE	_____ DATE
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Technologist: _____
 (Revised 2/19/14)