HENDRICKS REGIONAL HEALTH
Breast Center

Today's Date: _____

Patient Name: _____ **DOB:** _____

What is your goal for this visit today? _____

Allergies: _____

Medical Problems: (Check all that apply) **Year of Diagnosis/Treating Provider:**

- ○ Congestive heart failure _____
- ○ Heart Attack/Myocardial infarction _____
- ○ Coronary artery disease _____
- ○ High Blood pressure/Hypertension _____
- ○ COPD/Emphysema _____
- ○ Obstructive sleep apnea _____
- ○ Asthma _____
- ○ DVT or pulmonary embolism _____
- ○ Chronic kidney disease _____
- ○ Heartburn/GERD _____
- ○ Liver disease/Cirrhosis _____
- ○ Seizures _____
- ○ Stroke/TIA _____
- ○ Diabetes mellitus _____
- ○ Osteoporosis _____
- ○ Arthritis _____

Other medical problems:

_____

_____

Past Surgeries:	**Year of Surgery:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Past surgeries or procedures on the breast? (Check all that apply)

- ○ Cyst aspiration: _____
- ○ Abscess drainage: _____
- ○ Needle biopsy: _____
- ○ Surgical biopsy or excision: _____
- ○ Breast reduction: _____
- ○ Breast Augmentation/Implant placement: _____
- ○ Mastectomy: _____
- ○ Partial mastectomy/Lumpectomy: _____
- ○ Breast reconstruction: _____

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Family history of cancers:

Any personal or family history of cancer gene testing? ◯ Yes ◯ No

If yes, who was tested and what was the result? _____

Are you of Ashkenazi Jewish Decent? ◯ Yes ◯ No

Family history of cancers (*parents, children, siblings, grandparents, aunts, uncles, & 1st cousins)*

Please indicate if this is Maternal (mother's side) or Paternal (father's side)

Cancer Type	**Family Member(s)** Please indicate Maternal or Paternal	**Age of Diagnosis**
Breast		
Ovarian		
Colon		
Uterine		
Melanoma		
Pancreatic		
Stomach		
Prostate		
Other		

Social History:

Marital Status: _____ Occupation: _____

Who lives with you in your household? _____

Do you currently smoke or use any nicotine products including vaping? (Circle) Yes or No

How many years have you smoked? _____*How much do you smoke per day?* _____

Have you smoked or used any nicotine products including vaping in the past? (Circle) Yes or No

How many years? _____*How much per day?* _____*When did you stop?* _____

Do you drink alcohol? (Circle) Yes or No

How often do you drink? _____How many drinks in a week? _____

Medications (Include over the counter medications or supplements):

_____

_____

_____

_____

_____

_____

_____

_____

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What breast symptoms are you having? (Check all that apply)

Breast lump that you can feel. ◯ Right ◯ Left ◯ Both

How long have you been able to feel this? _____

How has this changed from when you first noticed this?

Describe: _____

Changes in the skin of your breast (check all that apply)

Redness of the breast ◯ Right ◯ Left ◯ Both

How long has this been going on? _____

Skin dimpling ◯ Right ◯ Left ◯ Both

How long has this been going on? _____

Skin thickening or swelling ◯ Right ◯ Left ◯ Both

How long has this been going on? _____

Changes in your nipple (check all that apply)

Nipple Inversion: ◯ Right ◯ Left ◯ Both

How long has this been going on? _____

Nipple rash/skin changes ◯ Right ◯ Left ◯ Both

How long has this been going on? _____

Nipple Discharge? ◯ Right ◯ Left ◯ Both

◯ Daily ◯ Sometimes ◯ Rarely

How long has this been going on? _____

Breast pain ◯ Right ◯ Left ◯ Both

Severity (Circle) No pain 0 1 2 3 4 5 6 7 8 9 10 Worse pain ever

How long has this been going on? _____

Have you ever had a mammogram? (Circle) Yes or No

Date of last mammogram: _____ *Location of last mammogram:* _____

Have you had any other imaging of the breast such as Breast MRI? (Circle) Yes or No

Describe: _____

Do you have a personal history of any cancer? (Circle) Yes or No Year diagnosed: _____

Describe: _____

_____

_____

What type of cancer treatment did you complete? (Check all that apply)

◯ *Chemotherapy:* _____

◯ *Radiation:* _____

◯ *Surgery:* _____

◯ *Hormonal Blocking Therapy:* _____

◯ *Other:* _____

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OB/Menstrual History:

Age at First Menstrual Cycle: _____Date of Last Menstrual Cycle: _____

Have you ever been pregnant? (Circle) Yes or No

If so, how many pregnancies have you had? _____

How many children have you had? _____

What was your age at your first live birth? _____

Present Menstrual Status? ◯ Premenopausal ◯ Menopausal ◯ Postmenopausal

If postmenopausal: *At, what age did you finish menopause?* _____

Have you had both your ovaries removed? (Circle) Yes or No *What year?* _____

If premenopausal:

Are you currently lactating/breastfeeding? (Circle) Yes or No

Is so, how long do you plan to continue breastfeeding? _____

Are you currently using any birth control? (Circle) Yes or No

If so, what type? _____

For how many years? _____

What other types of birth control have you used previously? _____

Are you planning on having more children in the future? (Circle) Yes No Not sure

Hormone Replacement History:

Are you currently using any hormone replacement? (Circle) Yes or No

If so, what hormones? (Check all that apply):

◯ *Estrogen* ◯ *Progesterone* ◯ *Estrogen/Progesterone* ◯ *Testosterone*

If so, what type (Check all that apply):

◯ *Pill* ◯ *Vaginal cream* ◯ *Topical Cream* ◯ *Pellet* ◯ *Other:*

How long have you used this hormone replacement? _____

How long do you plan to continue this hormone replacement? _____

Have you used any hormone replacement in the past? (Circle) Yes or No

If so, what hormones (Check all that apply):

◯ *Estrogen* ◯ *Progesterone* ◯ *Estrogen/Progesterone* ◯ *Testosterone*

If so, what type (Check all that apply):

◯ *Pill* ◯ *Vaginal cream* ◯ *Topical Cream* ◯ *Pellet* ◯ *Other:*

How long did you use this hormone replacement? _____

When did you stop this hormone replacement? _____

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Review of Systems

Constitutional

Appetite Change	Yes	No
Fatigue	Yes	No
Fever	Yes	No
Weight Change	Yes	No

Ear/Nose/Throat

Congestion	Yes	No
Ear Pain	Yes	No
Hearing Loss	Yes	No
Mouth Sores	Yes	No
Nosebleeds	Yes	No
Sore Throat	Yes	No
Ringing in Ears	Yes	No
Trouble Swallowing	Yes	No

Respiratory

Chest Tightness	Yes	No
Cough	Yes	No
Shortness of Breath	Yes	No
Wheezing	Yes	No

Cardiovascular

Chest Pain	Yes	No
Leg Swelling	Yes	No
Palpitations	Yes	No

Gastroenterology

Abdominal Pain	Yes	No
Blood in Stool	Yes	No
Constipation	Yes	No
Diarrhea	Yes	No
Nausea	Yes	No
Vomiting	Yes	No

Endocrinology

Cold Intolerance	Yes	No
Heat Intolerance	Yes	No

Urology

Dificulty Urinating	Yes	No
Painful Urination	Yes	No
Frequency	Yes	No
Blood in Urine	Yes	No
Urgency	Yes	No

Musculoskeletal

Joint Pain	Yes	No
Back Pain	Yes	No
Dificulty Walking	Yes	No
Joint Swelling	Yes	No
Muscle Pain	Yes	No

Dermatology

Color Change	Yes	No
Rash	Yes	No
Wound	Yes	No

Neurological

Dizziness	Yes	No
Headaches	Yes	No
Numbness	Yes	No
Seizures	Yes	No
Weakness	Yes	No

Hematology

Swollen Lymph Nodes	Yes	No
Bruises/Bleeds Easily	Yes	No

Psychiatric

Confusion	Yes	No
Depression	Yes	No
Nervous/Anxious	Yes	No
Sleep Disturbance	Yes	No

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BELOW IS FOR CLINIC STAFF TO COMPLETE

WEIGHT_____HEIGHT_____BP_____PULSE_____RESP_____TEMP_____

BRA SIZE_____LATEX ALLERGY_____

Notes

_____

_____

_____

_____

_____

_____

Provider Notes: