

**Breast Cancer History And Risk Assessment**

Patient name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

Date of Last: Mammogram \_\_\_\_\_ Ultrasound \_\_\_\_\_

Age of first menstrual period: \_\_\_\_\_ Are you menopausal? \_\_\_\_\_

Have you taken hormone replacement therapy? Yes/No How long? \_\_\_\_\_

LMP: \_\_\_\_\_ # Pregnancies?: \_\_\_\_\_ # Births?: \_\_\_\_\_

Age of first live birth: \_\_\_\_\_ Did you breastfeed? Yes/No Any problems? \_\_\_\_\_

Previous breast biopsy? Yes/No Date \_\_\_\_\_ Result of biopsy \_\_\_\_\_

Previous breast surgery? Yes/No If yes, when? \_\_\_\_\_ Type of surgery \_\_\_\_\_

Any recent changes and/or concerns:

- |  | Right                    | Left                     | Cyclic                   |
|--|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> Lump                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Nipple Discharge        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Nipple /skin retraction | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Erythema/swelling       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Rash/scaling/itching    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Breast pain             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Other: _____            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> None                    |                          |                          |                          |

**FAMILY HISTORY** (both mother/father history is relevant. Include parents, sisters, aunts, cousins)

	<u>Relation</u>	<u>Age at Diagnosis</u>
Breast Cancer	_____	_____
	_____	_____
	_____	_____
Ovarian Cancer	_____	_____
Other	_____	_____
	_____	_____

Any other breast health concerns?

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