

Breast Information Sheet

Name: _____ **Age:** _____ **Date:** _____

Family History of Breast Cancer (Maternal or Paternal)		Y	N
Mother _____	Sister(s) _____	Aunt(s) _____	Grandmother _____
Daughter _____	Cousin _____	Other _____	

Menstrual Hx: Age at Onset: _____	Age at Menopause: _____	Last Menstrual Period: _____
Hormonal Therapy: Oral Contraceptive _____		
Hormone Replacement Therapy: _____		
Childbirth History: # Of Pregnancies _____	# Of Children _____	
Age at First Childbirth _____	Did you Breastfeed? Y	N

Mammogram	Y	N	Date of last _____
Sonogram	Y	N	Date of last _____
MRI	Y	N	Date of last _____

Reason for visit:			
Lump	R	L	duration of complaint _____
Pain	R	L	duration of complaint _____
Nipple discharge	R	L	duration of complaint _____
Change in breast appearance	R	L	duration of complaint _____
Abnormal mammogram	R	L	
Second opinion			

Breast Cancer Treatments	Y	N		
Lumpectomy	Y	N	R	L
Radiation	Y	N		
Mastectomy	Y	N	R	L
Without reconstruction	Y	N		
With reconstruction	Y	N		
Chemotherapy	Y	N		