

Patient ID _____		DOB _____	Age _____
Mrs Ms _____ Miss Dr _____ Last _____		First _____	MI _____
Mr Sister _____			
Home phone _____	Work phone _____	x _____	Cell phone _____
Address _____		Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Prior Mammograms? <input type="checkbox"/> No (baseline) <input type="checkbox"/> Yes - Indicate location _____ _____
City _____	State _____	Weight _____ lbs	
Zip _____	Country _____	Height _____ ft _____ in	
		Ethnicity _____	

Employer _____	Insurance: _____
Referring doctor _____	Additional report: _____

► Gynecological History First menstrual period at age _____ Number of live births _____ Menopause at age _____ Left ovary removed at age _____ Hysterectomy at age _____ Right ovary removed at age _____ First full-term pregnancy at age _____ Date of last period: _____ Are you pregnant? _____	► Personal Risk Factors <input type="checkbox"/> Breast cancer gene at Age _____ <input type="checkbox"/> History of breast cancer <input type="checkbox"/> History of endometrial cancer <input type="checkbox"/> History of ovarian cancer <input type="checkbox"/> History of high-risk lesion <input type="checkbox"/> History of colon cancer	► Family Breast Cancer Relative _____ at Age _____ _____ _____
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► Risk for Osteoporosis				
N	Y	Been told you have osteopenia or osteoporosis?	Do you take medicine for your bones? If yes, please list.	Prior DXA (bone density exam)? <input type="checkbox"/> No <input type="checkbox"/> Yes Date & results
N	Y	Ever break a bone? What & when:		
N	Y	Height loss?		

► Indicate ALL breast procedures and dates including cyst aspirations, biopsies, breast cancer surgery and treatment <input type="checkbox"/> NONE	Staff comments _____ _____ _____												
► Hormone History <table style="width:100%; border-collapse: collapse;"> <tr> <th style="width:15%;">Use now</th> <th style="width:20%;">First use (age)</th> <th style="width:20%;">Last use (age)</th> <th style="width:45%;">Duration of use</th> </tr> <tr> <td>Oral Contraceptives <input type="checkbox"/></td> <td>_____</td> <td>_____</td> <td>_____ yrs _____ mos</td> </tr> <tr> <td>Hormone replacement <input type="checkbox"/></td> <td>_____</td> <td>_____</td> <td>_____ yrs _____ mos</td> </tr> </table>		Use now	First use (age)	Last use (age)	Duration of use	Oral Contraceptives <input type="checkbox"/>	_____	_____	_____ yrs _____ mos	Hormone replacement <input type="checkbox"/>	_____	_____	_____ yrs _____ mos
Use now	First use (age)	Last use (age)	Duration of use										
Oral Contraceptives <input type="checkbox"/>	_____	_____	_____ yrs _____ mos										
Hormone replacement <input type="checkbox"/>	_____	_____	_____ yrs _____ mos										

► Reason for your visit today Breast symptoms, concerns, history - within the year <table border="1" style="width:100%; border-collapse: collapse;"> <tr><td>► N</td><td>Y</td><td>Breast lump, mass, thickening?</td></tr> <tr><td>► N</td><td>Y</td><td>Skin changes, dimpling, thickening?</td></tr> <tr><td>► N</td><td>Y</td><td>Nipple symptoms (discharge, dry, pulling inward)?</td></tr> <tr><td>► N</td><td>Y</td><td>Pain?</td></tr> <tr><td>► N</td><td>Y</td><td>Large axillary lymph nodes?</td></tr> <tr><td>► N</td><td>Y</td><td>Told or worried you have a breast problem(s)?</td></tr> <tr><td>► N</td><td>Y</td><td>Ever been told you have breast cancer?</td></tr> <tr><td>► N</td><td>Y</td><td>Implants? Type?</td></tr> </table>	► N	Y	Breast lump, mass, thickening?	► N	Y	Skin changes, dimpling, thickening?	► N	Y	Nipple symptoms (discharge, dry, pulling inward)?	► N	Y	Pain?	► N	Y	Large axillary lymph nodes?	► N	Y	Told or worried you have a breast problem(s)?	► N	Y	Ever been told you have breast cancer?	► N	Y	Implants? Type?	<div style="border: 1px solid black; padding: 5px; text-align: center;"> Patient area only </div> ► PLEASE EXPLAIN ANY YES RESPONSE Include additional information not listed on this form.
► N	Y	Breast lump, mass, thickening?																							
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► I state the above information is truthful. I have indicated any and all breast problems and concerns.
 ► I will contact the Charleston Breast Center if I do not receive my results within 30 days.
 ► It is my responsibility to verify insurance.

Signed: _____ Date: _____