TEXAS BREAST SPECIALISTS

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This form was designed to reduce the duplication of medical histories taken by many of the physicians you may encounter in the course of your breast care. Please complete the following questions using a blue or black pen. Leave questions blank if you are unsure how to answer the question; a medical staff member will be reviewing the form with you before you see the physician. Thank you for taking the time to fill out this form.

Ethnic Origin

❑ Asian American ❑ African American ❑ Caucasian ❑ Hispanic ❑ Ashkenazi Jewish Ancestry
❑ Other _____

Referral Information

Who referred you to our office? ❑ Doctor ❑ Family ❑ Friend ❑ Self ❑ Internet

Please specify the person's name (if applicable): _____

Main Reason for Visit (please check only one)

❑ Abnormal mammogram ❑ Breast Pain ❑ Breast Lump ❑ Other: _____

Breast lump, pain, or "other" first found by: ❑ Me ❑ Doctor ❑ Mammogram

Are You Currently Having Any of the Following Problems?

1. Lumps in breast: ❑ No ❑ Right ❑ Left ❑ Bilateral Since when? _____
   How did you find the lump? _____
2. Nipple discharge: ❑ No ❑ Right ❑ Left ❑ Bilateral Since when? _____
   Method of detection: ❑ Spontaneous ❑ Expressed
   Color: ❑ Brown ❑ Green ❑ Red ❑ Clear ❑ White ❑ _____
3. Breast tenderness/pain: ❑ No ❑ Right ❑ Left ❑ Bilateral Since when? _____
   My breast pain is: ❑ Continuous ❑ On and Off
4. Breast redness or swelling: ❑ No ❑ Right ❑ Left ❑ Bilateral Since when? _____
5. Prior breast injury: ❑ No ❑ Yes
6. Other complaints: _____

_____

_____

Last Name, First _____

Med Rec# _____ PCP _____

DOB: _____ Age _____ SC-02 Rev. 10/12

PATIENT ID STICKER

BREAST HEALTH QUESTIONNAIRE

Mammography Information

Have you had a previous mammogram? ❑ No ❑ Yes: Where? _____ When? ____ / ____ / _____

Date of your first mammogram: ____ / ____ / _____

Do you practice monthly breast self-exams? ❑ No ❑ Yes ❑ Sometimes

Ob/Gyn History

1. Have you had a hysterectomy? ❑ No ❑ Yes: Date of surgery: ____ / ____ / _____
   Have your ovaries been removed? ❑ No ❑ One ❑ Both ❑ Unsure
2. Date of most recent pelvic exam: ____ / ____ / _____
3. Are you pregnant? ❑ Unsure ❑ No ❑ Yes: Due date - ____ / ____ / _____
4. Age at first menstrual cycle: _____
5. Are you still having periods? ❑ No ❑ Yes
6. Beginning date of last menstrual cycle: ____ / ____ / _____
7. Which option best describes you:
   ❑ Have not had menopause yet ❑ Currently undergoing menopause
   ❑ Not sure if I have undergone menopause
   ❑ Already underwent menopause at age _____ *Type of Menopause:*
   ❑ Natural (periods just stopped by themselves)
   ❑ Surgical (ovaries and/or uterus removal)
8. Number of pregnancies: _____ Live-births: _____ Miscarriages/Abortions: _____
9. Age at first birth: _____ Age at last birth: _____
10. Did you ever breast feed? ❑ No ❑ Yes
    Age at first breast feeding: _____ How long (All the children together) ? _____ months

Hormonal Medical History

1. Birth control pills: ❑ Never used ❑ On and Off use ❑ One long continuous period of use
   Age started: _____ Total years used: _____ Currently taking birth control pills? ❑ No ❑ Yes
2. Hormone replacement therapy: ❑ Never used ❑ On and Off use ❑ One long continuous period of use
   Age started: _____ Total years used: _____ Are you currently taking hormones? ❑ No ❑ Yes
3. Infertility drugs/hormones: ❑ Never used ❑ On and Off use ❑ One long continuous period of use
   Age started: _____ Age stopped: _____ Total months used: _____

Breast Surgery/Treatment History

1. Have you ever had a breast cyst(s)? ❑ No ❑ Right ❑ Left ❑ Both
   (Cysts are little sacs of fluid that are sometimes drained with a needle or may be seen on a mammogram or ultrasound.)

2. Number of needle biopsies you have had: ❑ None ❑ Right _____ ❑Left _____
(Needle biopsies are done in the office or in the breast imaging area.)
Type of needle biopsy: ❑ FNA ❑ Core ❑ Unsure

3. Number of surgical biopsies you have had: ❑ None ❑ Right _____ ❑ Left _____
(These involve cutting into your skin and are usually done in the operating room.)
Did the pathology show ADH (atypical ductal hyperplasia)?: ❑ No ❑ Yes ❑Unsure
Did the pathology show LCIS (lobular carcinoma in situ)?: ❑ No ❑ Yes ❑ Unsure
Age when first diagnosed with LCIS: _____

4. Have you ever been diagnosed with breast cancer? ❑ No ❑ Right ❑ Left ❑ Both
If yes, what type of surgery have you had for breast cancer? ❑ Removal of part of the breast
❑ Removal of the whole breast
Did you have reconstruction of the breast? ❑ No ❑ Yes

5. Have you ever had breast implants? ❑ No ❑ Yes: If yes, do you currently have implants? ❑ No ❑ Yes
Have you ever had silicone implants? ❑ No ❑ Yes
Any trouble with leaking implants? ❑ No ❑ Yes

Your Health History

1. Height: _____ feet _____ inches Weight: _____ pounds
2. Do you have a history of cancer other than breast cancer? ❑ No ❑ Yes
3. Have you ever had radiation therapy? ❑ No ❑ Yes
4. Have you ever had chemotherapy? ❑ No ❑ Yes
5. Do you have rheumatoid arthritis, lupus, Raynaud's or scleroderma? ❑ No ❑ Yes
6. Have you ever tested positive for AIDS or HIV? ❑ No ❑ Yes
7. Have you ever had general anesthesia? ❑ No ❑ Yes ❑ Unsure
If yes, were there any problems? ❑ No ❑ Yes
Do you have any family history of anesthesia problems? ❑ No ❑ Yes
8. Do you have any bleeding problems? ❑ No ❑ Yes
Are you taking any blood thinners? ❑ No ❑ Yes
Are you on daily aspirin? ❑ No ❑ Yes
9. Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widow
10. Highest level of education: ❑ High School ❑ Some College ❑ College Degree
11. Current employment status: ❑ Employed ❑ Retired ❑ Disabled ❑ Unemployed
Occupation: _____
Occupational toxin exposure history: _____
12. Caffeine (Regular use): ❑ NONE
❑ coffee: _____ cups per day / week / month (circle one)
❑ tea: _____ cups per day / week / month (circle one)
❑ soda: _____ cans per day / week / month (circle one)
❑ chocolate bar: _____ # per day / week / month (circle one)

13. Alcohol use: ❑ No ❑ Yes ❑ Occasionally (Less than 1 drink per week)
If yes, how many drinks per week? _____ Beer: _____ Wine: _____ Hard liquor: _____

14. Tobacco use (ever): ❑ No ❑ Yes ❑ Sporadic use
If yes, type: ❑ Cigarette ❑ Cigar ❑ Pipe ❑ Snuff ❑ Previous smoker
For cigarette smokers: _____ packs/day for _____ years

15. Have you ever taken street/recreational drugs? ❑ No ❑ Yes: specify - _____

Current medications and doses: _____

_____

_____

Drug or food allergies and reactions: _____

_____

_____

List all previous surgeries and dates: _____

_____

_____

List any medical problems and when they were diagnosed: _____

_____

_____

Family History

Please list all relatives including yourself, sons, daughters, mother, father, sisters, brothers, maternal and paternal aunts and uncles, and grandparents. Please include any major medical problems and, if they were diagnosed with cancer, ther age at that time. Circle "Living" or "Deceased" and note the current age, or age at death. If you are adopted, only include your family members that are genetically related to you.

Relationship	Living or Deceased	Age	Major Medical Problems	Type of Cancer(s) & Age at Diagnosis
	◯			
Daughter / Son	Living Deceased			
Daughter / Son	Living Deceased			
Daughter / Son	Living Deceased			

Mother	Living Deceased			
Father	Living Deceased			
Sibling	Living Deceased			
Sibling	Living Deceased			
Maternal Grandmother	Living Deceased			
Maternal Grandfather	Living Deceased			
Maternal Aunt / Uncle	Living Deceased			
Maternal Aunt / Uncle	Living Deceased			
Paternal Grandmother	Living Deceased			
Paternal Grandfather	Living Deceased			
Paternal Aunt / Uncle	Living Deceased			
Paternal Aunt / Uncle	Living Deceased			

(If additional space is needed, please write on back of this page in same format.)

I have fully reviewed the questionnaire and answered all questions truthfully and to the best of my knowledge. I am aware that my answers could affect my health care, or that of the patient for whom I am responsible:

_____ _____/_____/_____

Patient Signature Date

_____

Relationship *(if signature of parent or guardian)*

I have read and reviewed these results with the patient or responsible party.

_____ _____/_____/_____

Physician's Signature Date

REVIEW OF SYMPTOMS

Please review and check the appropriate box for any problems you may have now, or had in the past.

General
- ___ Unable to exercise
- ___ Weight Loss
- ___ Planned Weight Loss
- ___ Weight Gain
- ___ No recent weight gain/loss
- ___ Radiation Tx
- ___ Cancer Chemotherapy

Constitutional
- ___ Fever
- ___ Night Sweats
- ___ Loss of Appetite

Infection
- ___ Recent Cold/Flu
- ___ Tuberculosis

Mouth/Throat
- ___ Dental problems
- ___ Mouth Ulcers
- ___ Gum Bleeding/Pain
- ___ Hoarseness
- ___ Difficulty Swallowing

Cardiac
- ___ Heart Attack
- ___ Heart Disease
- ___ High Blood Pressure
- ___ Heart Murmur
- ___ Angina
- ___ Irregular Heart Beats
- ___ Short of Breath
- ___ Palpations
- ___ Mitral Valve Prolapse
- ___ Heart Failure
- ___ Tachycardia
- ___ Pericardial Effusion
- ___ Pacemaker
- ___ Aneurysm
- ___ Leg/Food Edema
- ___ Premature Ventricular Contractions

Respiratory
- ___ Chest Pain
- ___ Asthma
- ___ Chronic Cough
- ___ Pneumonia
- ___ Bronchitis
- ___ Breathing Problems
- ___ Wheezing
- ___ Emphysema
- ___ Short of Breath
- ___ Pleurisy

Gastro-Intestinal
- ___ Stomach Ulcers
- ___ Duodenal Ulcers
- ___ Hepatitis
- ___ Nausea
- ___ Diarrhea
- ___ Blood in Stool
- ___ Heartburn
- ___ Vomiting
- ___ Change in Bowel Habits
- ___ Colitis
- ___ Vomiting Blood
- ___ Intestinal Ulcers
- ___ Liver Problems
- ___ Jaundice
- ___ Hiatal Hernia
- ___ Hemorrhoids
- ___ Constipation
- ___ Irritable Bowel Syndrome

Genito-Urinary
- ___ Kidney Problems
- ___ Nephritis
- ___ Kidney Stone
- ___ Blood in Urine
- ___ Hot Flashes
- ___ Frequent Urination
- ___ Vaginal Discharge
- ___ UTI
- ___ Incontinence of Urine/Stool
- ___ Vaginal Spotting
- ___ Sexual Problems
- ___ Burning on Urination

Hematological/Lymphatic
- ___ Bleeding Tendency
- ___ Hemophilia
- ___ Easy Bruising
- ___ Anemia
- ___ Lymphoma
- ___ Blood Transfusion
- ___ Leukemia
- ___ Blood Clots
- ___ Red Cell Problems
- ___ Platelet Problems
- ___ Anticoagulants
- ___ Enlarged Lymph Nodes

Endocrine
- ___ Thyroid Problems
- ___ Steroid Use
- ___ Intolerance to Heat/Cold
- ___ Diabetes
- ___ Diabetes (Gestational)

Neurological
- ___ Nerve Injury
- ___ Paralysis
- ___ Headaches
- ___ Stroke
- ___ Seizure
- ___ Migraine Headaches
- ___ Speech Problems
- ___ Balance Problems
- ___ Fainting/Blackouts
- ___ TIA

Rheumatoid
- ___ Rheumatic Fever
- ___ Back Injury
- ___ Neck Injury
- ___ Herniated Disc
- ___ Arthritis
- ___ Rheumatoid Arthritis

Musculoskeletal
- ___ Leg cramps/pain
- ___ Weakness
- ___ Muscle Aches
- ___ Osteoporosis
- ___ Scoliosis

Psychiatric
- ___ Depression
- ___ Mental Problems
- ___ Sleep Problems
- ___ Anxiety

Oro-Gastric
- ___ Esophageal Ulcers

Eyes/Ears/Nose
- ___ Sinus Disease
- ___ Cataracts
- ___ Recent Visual Change
- ___ Nose Bleeds
- ___ Double Vision
- ___ Ringing in Ears
- ___ Hearing Loss

Skin
- ___ Rashes
- ___ Sores
- ___ Pigmented Moles
- ___ Hives
- ___ Skin Ulcers