

**The Breast Cancer Institute at Steeplechase Cancer Center
Breast History and Risk Assessment Form**

Name: _____

Date: ____/____/____

Height: _____ Weight: _____

Birthdate: __/__/____

Race: _____

Personal Breast History

Location

Have you ever had a previous mammogram?	Y	N			What years? _____	Results? _____
Have you ever had a previous ultrasound?	Y	N			What years? _____	Results? _____
Have you ever had previous MRI?	Y	N			What years? _____	Results? _____
Have you ever had a previous breast biopsy?	Y	N	Right	Left	When? _____	Results? _____
Have you ever had a breast cyst aspirated?	Y	N	Right	Left	When? _____	
Do you have breast pain?	Y	N	Right	Left		
Do you have a lump that you can feel?	Y	N	Right	Left		
Do you have a lump that your doctor can feel?	Y	N	Right	Left		
Do you have regular periods?	Y	N			Date of Last Menstrual Period? ____/____/____	
Do you have a nipple discharge?	Y	N				
Are you BRCA positive?	Y	N				

Family History:

Have **YOU** or any of your **family** members ever been diagnosed with any of the following?

Breast Cancer	Y	N	What relation? _____	Mother or father's side? _____	Age at diagnosis ____	Present Age _____
Colon Cancer	Y	N	What relation? _____	Mother or father's side? _____	Age at diagnosis ____	Present Age _____
Ovarian Cancer	Y	N	What relation? _____	Mother or father's side? _____	Age at diagnosis ____	Present Age _____
Uterine Cancer	Y	N	What relation? _____	Mother or father's side? _____	Age at diagnosis ____	Present Age _____

Radiation History:

Have you ever received radiation exposure to your chest wall? (e.g., Hodgkin's therapy, repeated fluroscopies) Y N

Alcohol History: Do you drink alcohol? Y N How many drinks per week? _____

Tobacco History: Have you ever smoked? Y N Age started: _____ Age when quit: _____ Packs per day: _____

Sun Exposure History: Frequent sun exposure (past or present)? Y N Frequent sunburns? Y N

Reproductive History:

Age at first period _____ Age at menopause _____

Have you ever been pregnant? Y N If yes, how many times? _____ If yes, have you ever had preclampsia? Y N

(If not, skip down to the *Hormonal / Drug History Section*)

Please fill in the length of each pregnancy by the # of weeks: (a full-term pregnancy is 40 weeks)

Pregnancy	1st	2nd	3rd	4th	5th	6th	7th
How old were you at the end of each pregnancy							
What was the outcome of each pregnancy?							
Live Birth: How many weeks?							
Multiple Birth: How many weeks?							
Still Birth: How many weeks?							
Miscarriage: How many weeks?							
D&C after fetus (baby) died: How many weeks?							
Abortion: How many weeks?							
Ectopic Pregnancy: How many weeks?							
Did you breastfeed? How many weeks?							

Hormonal Drug History:

Have you ever used a hormone replacement? (e.g., estrogen, progesterone, Provera, Premarin) Y N

Name: _____ How long used? _____ Age when started: _____

Have you ever used fertility drugs? (e.g., Clomid, Pergonal) Y N Age when started: _____

Name: _____ How long used? _____

Contraceptive History:

Have you ever used any of the following?

Birth Control Pills? Y N

Name: _____ Age when started: _____ Age when stopped: _____ Reason for discontinuing? _____

Name: _____ Age when started: _____ Age when stopped: _____ Reason for discontinuing? _____

Name: _____ Age when started: _____ Age when stopped: _____ Reason for discontinuing? _____

Contraceptive injectable and/or device? (e.g., Nueva Ring, Norplant, Depoprovera, IUD, Patch) Y N Age when started: _____

Name: _____ How long used? _____