1960 Breast Care Center-Patient History Questionnaire

PID:______________ **BRCA:**______________

Last Name: ________________________________ **First Name**:______________________________ **Age**:_______

Home Phone:___________________________ **Cell Phone:** _________________________**Date of Birth**___________

Address: __________________________________**Apt #**_____ **City:**_________________ **State:** ____**Zip:**________

Doctor's Name:_________________________________ **Date of last visit:** _______________________________

Have you had a **mammogram** before? Yes☐ No☐ **WHEN:** _______ **WHERE:**_________________________________

Ultrasound? Yes☐ No☐ **MRI?** Yes☐ No☐ **History of HYSTERECTOMY?** Yes☐ No☐ **If so, WHEN:** _________

LAST MENSTURAL PERIOD: ____________ ______ **Number of children?**_______ **Age at first birth:** ______________

Reason for EXAM:	List **FAMILY** history **of BREAST cancer?**	List **FAMILY** history **of Ovarian cancer?**
Screening/ Routine	**Relation:** ______________**Age:**______	**Relation:** ______________**Age:**______
Follow-up	**Relation:** ______________**Age:**______	**Relation:** ______________**Age:**______
New Symptom	**Relation:** ______________**Age:**______	**Relation:** ______________**Age:**______
	Relation: ______________**Age:**______	**Relation:** ______________**Age:**______

History of Hormones:	**PERSONAL history** of **BREAST** cancer? Yes☐ No☐	**PERSONAL history** of **BREAST surgery/biopsy?**
Last taken? _______	**OVARIAN** cancer**?** Yes☐ No☐ **WHEN:**___________	**Reduction? WHEN** __________
Estrogen	**Mastectomy:** Right☐ Left☐ **WHEN:**____________	**Biopsy (cuts):** Right☐ Left☐ **WHEN:**____________________
Progesterone	**Lumpectomy:** Right☐ Left☐ **WHEN:**____________	**Needle biopsy:** Right☐ Left☐ **WHEN:** ____________________
Birth Control	**Chemotherapy:** Yes☐ No☐	
Other ________	**Radiation:** Yes☐ No☐ **Tamoxifen:** Yes☐ No☐	

Do you have **IMPLANTS?** Yes☐ No☐ If so, **WHEN:**___________ **Removed:** _____________ **Replaced:**____________

Are you **currently** experiencing **NEW** problems in your **breasts**? **Lump:** Right☐ Left☐ **WHEN:**___________

Pain: Right☐ Left☐ **WHEN:**_________ **Nipple discharge:** Right☐ Left☐ **WHEN:**________ **Other:** ___________

Henda's Law was presented to the patient at time of the exam

Patient Signature: ____**Date:** ______________________

*****DO NOT WRITE IN THIS AREA: FOR TECHNICAL USE ONLY*****