Somerset Surgical Associates

Breast History and Risk Assessment Form

Patient Name: _____ Date: _____

Height:_____ Weight:_____ DOB:_____ Race:_____

Personal Breast History *Location*

Have you ever had breast cancer? Y N If yes, what treatment did you have? _____
_____

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 nipple discharge?	Y	N			
Are you BRCA positive? (genetic test)	Y	N			
Do you have breast pain?	Y	N	Right	Left	
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 breast 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 regular periods?	Y	N			Date of last menstrual period:_____

Personal and Family Cancer 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 to your chest wall? (e.g., Hodgkin'stherapy, repeated fluoroscopies) 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

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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 preeclampsia? 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

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 died: How many weeks?						
Abortion: How many weeks?						
Ectopic Pregnancy: How many weeks?						
Did you breastfeed? Yes No (Please Circle) How many weeks?						

Hormonal Drug History:

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

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

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

Drug Name:_____ How long used? _____

Did you or your mother ever use DES (Diethylstilbestrol)? Y N When?_____

Contraceptive History:

Have you ever used any of the following?

Birth Control Pills? Y N

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

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

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

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

Drug Name:_____ How long used?_____