BREAST VISIT INFORMATION SHEET

Name: _____ Date: _____ Age: _____

Age of First Period: _____ Date of Last Period: _____

Age of completed menopause, if applicable: _____

Number of Full Term Pregnancies: _____

Your age at Time of First Childbirth: _____

Did you breast feed any of your children? ____YES ____NO

Did you ever take Birth Control Pills? ____YES ____NO How Long? _____

Have you ever taken any type of Estrogen? ____Yes ____NO Specify Type: _____

How long did you take this medication?_____

Have you ever had any miscarriages? _____YES _____NO How many? _____

Do you have any type of nipple discharge? _____YES _____NO

Have you ever had any type of breast surgery or Biopsies? _____YES _____NO

What type and when? _____

Race/ Ethnicity: _____

Are you of Ashkenazi or Central European Jewish descent? _____YES _____NO

Is there any history of breast cancer in your family? _____

How old were they when they were diagnosed? _____

Do you OR any family member have a history of ovarian cancer? _____YES _____NO

Have EITHER you or a family member had genetic testing? _____YES ____NO Who? _____

Is there any other type of cancer in your family on either maternal or paternal side, including children, grandparents, siblings, aunts, uncles, cousins? _____YES _____NO

What type of cancer and who in your family was diagnosed?_____