Breast Care Center, A *branch* of Cedar Valley Medical Specialists, P.C.
1753 West Ridgeway Ave., Suite 104, Waterloo, IA 50701

#_____ Name:_____ DOB:_____
DATE:_____

1. What is the reason for your visit today?_____
2. What age were you at your first live birth? _____
3. Did you breastfeed? Yes No
4. Age your menstrual periods started _____ Date of your last menstrual period_____
5. Age at which you stopped having your menstrual cycle _____
6. Do you currently take: Birth Control Pills? Yes No Hormone replacement? Yes No
7. Did you ever use hormone replacement? Yes No If yes – for how long? _____
8. Any breast or nipple discharge? Yes No Is the discharge bloody? Yes No
   Which breast? Right Left Is the drainage spontaneous? Yes No
9. Have you had any lumps in your breast before? Yes No If yes, which breast? Right Left
10. Have you had any breast biopsies done? Yes No
    If yes, Which breast? Right Left How many?_____ Findings:_____
11. Do you do monthly self breast examinations? Yes No Sometimes Rarely
    Would you like information on how to do breast self exam today at your visit? Yes No
12. When and where did you have your last mammogram?_____

Personal or Family History of <u>Breast, Ovarian or Pancreatic</u> Cancer:

Family includes *parents, children, siblings, grandparents, aunts, uncles & cousins*
Please mark below if there is a *personal or family history* of breast or ovarian cancer.
Please indicate their relation to you and on which side of your family, also their *age when diagnosed.*

WHO?	Breast Age @ diagnosis	Ovarian Age @ diagnosis	Breast Cancer in both breasts OR multiple primary breast cancer Age @ diagnosis	Male Breast Cancer Age @ diagnosis	Pancreatic Cancer Age @ diagnosis
Self					
Your Siblings					
Mother's Side <u>Your</u> Aunts, Uncles, Grandparents, 1st Cousins					
Father's Side <u>Your</u> Aunts, Uncles, Grandparents 1st Cousins					
Your Children					

13. Are you of Ashkenazi Jewish decent? Yes No
14. Any personal or family history of BRCA gene testing? Yes No
    If yes, who was tested and what was the result?_____

Gail Score _____ **5yr** _____ **Lifetime**