

Breast Care Center, 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. At what age did you go through menopause? _____
6. Do you **currently take**: Birth Control Pills? Yes No How long have you taken birth control pills? _____
Do you **currently take**/use hormone replacement? Yes No If yes, for how long? _____
7. Did you **ever use** hormone replacement? Yes No If yes – for how long? _____
8. Any breast or nipple discharge? Yes No What color is the drainage? _____
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 Breast, Ovarian or Pancreatic 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, if known*.

WHO?

Breast

* Age @ diagnosis

**Current Age or Age at death

Ovarian

Age @ diagnosis

Male Breast Cancer

Age @ diagnosis

Pancreatic Cancer

Age @ diagnosis

	Breast * Age @ diagnosis **Current Age or Age at death	Ovarian Age @ diagnosis	Male Breast Cancer Age @ diagnosis	Pancreatic Cancer Age @ diagnosis
Self				
Your Siblings				
Mother's Side <i>Your Aunts, Uncles, Grandparents, 1st Cousins</i>				
Father's Side <i>Your Aunts, Uncles, Grandparents 1st Cousins</i>				
Your Children				

13. Are you of Ashkenazi Jewish decent? Yes No

14. Any personal or family history of any genetic testing? Yes No

If yes, who was tested and what was the result? _____



Tyrer Cuzick v8 _____ % Lifetime Gail Score _____ % 5 year _____ % Lifetime