

# 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 \_\_\_\_\_

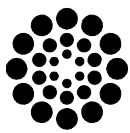
### Radiation History:

Have you ever received radiation to your chest wall? ( e.g., Hodgkin's therapy, 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	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>	5 <sup>th</sup>	6 <sup>th</sup>

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? \_\_\_\_\_