

BREAST CARE CONSULTANTS OF NORTHERN VIRGINIA
Female Breast Health Intake Form

Appointment Date: _____

Name: _____ Birth Date: _____ Age: _____ Race: _____
Are you of Ashkenazi Jewish heritage?
Yes No

How may we help you today? _____

Who referred you to our office today? _____

Who is your primary care doctor? _____

Who is your OB/GYN? _____

History of Present Illness

Did you or your doctor FEEL a mass in your breast? Yes No
If yes, which breast is it in? Right Left Both
When did someone notice it? _____

Was an abnormality or mass discovered on routine, screening mammography? Yes No
If yes, which breast is it in? Right Left Both

When was your last mammogram? _____

Where was it done? _____

Do you have any nipple discharge? Yes No
If yes, which nipple is it from? Right Left Both
How long has it been going on? _____
What color is it? Clear Bloody Green Yellow Milky Brown Cheesy
Does it come out by itself or only when you squeeze your nipple? _____ By itself
_____ When I squeeze

Do you have any breast pain? Yes No
If yes, which breast is it in? Right Left Both
Does it get worse around your periods? Yes No
When did it start? _____

Have you undergone a biopsy for any of the ABOVE complaints? Yes No
If yes, where? _____
When? _____
How? _____

Breast Health Risk Factors

How old were you when you began having periods? _____ years old

Are you still having periods? Yes No
If yes, when was your last period? _____
If no, how old were you when you went through menopause? _____

Have you had a hysterectomy (removal of uterus/womb)? Yes No
If yes, how old were you at the time? _____ years old
Why was it removed? _____

Do you still have your ovaries? Yes No

Have you ever used hormonally-based contraceptives (ie birth control) inc. Mirena IUD? Yes No
If yes, for how long? _____ years Current use? Yes No

Have you ever taken hormone replacement therapy (HRT) for menopausal symptoms? Yes No
If yes, for how long? _____ years Current use? Yes No

Have you ever used fertility medications (by mouth or injections)? Yes No
If yes, for how many cycles? _____ What medications? _____

Have you ever been pregnant? Yes No
If yes, how many times? _____
How many children did you give birth to? _____
How old were you when you gave birth to your 1st child? _____ years old
Did you breastfeed with any of your children? Yes No
If yes, for how long? _____

Have you ever had a breast biopsy in the past? Yes No
If yes, how many biopsies? _____
Which breast? Right Left
What type of biopsy? _____
When? _____
What was the result? _____

Have you ever had any other type of breast surgery/procedures in the past? Yes No
If yes, which breast? Right Left Both
What did you have done? _____
When? _____

Have you ever had external beam radiation therapy of your neck or chest? Yes No
If yes, where and when? _____

Have you ever had breast cancer? Yes No
If yes, when? _____
Which breast? Right Left
What surgery did you have? Lumpectomy Mastectomy
Did you have lymph nodes removed/biopsied? Yes No How many? _____
Did you have chemotherapy/Herceptin? Yes No
Did you have hormonal/endocrine treatment? Yes No
Did you have radiation? Yes No

Have any of your family members (including both your mother's and father's sides) been diagnosed with breast cancer? Yes No
If yes, who? _____ Age at diagnosis _____ Living or deceased
_____ Age at diagnosis _____ Living or deceased

Have you or any family members had genetic counseling and/or genetic testing for cancer? Yes No

Have any of your family members had any of these other types of cancer? If so, who and when?
Ovarian? _____ Age at diagnosis _____
Endometrial? _____ Age at diagnosis _____
Colon? _____ Age at diagnosis _____
Gastric? _____ Age at diagnosis _____
Thyroid? _____ Age at diagnosis _____
Prostate? _____ Age at diagnosis _____
Pancreas? _____ Age at diagnosis _____
Kidney? _____ Age at diagnosis _____
Melanoma? _____ Age at diagnosis _____
Adrenocortical carcinoma? _____ Age at diagnosis _____
Leukemia? _____ Age at diagnosis _____
Sarcoma? _____ Age at diagnosis _____
Brain? _____ Age at diagnosis _____

What is your current brasserie band and cup size? _____

Past Medical and Surgical History

Mark any medical problems that you have or have had in the past and explain.

- Arthritis _____
- Diabetes _____
- Digestive Problems _____
- Asthma or Other Lung Problems _____
- High Blood Pressure _____
- High Cholesterol _____
- Heart Problems _____
- Osteoporosis _____
- Stroke _____
- Seizures _____
- Thyroid Problems _____
- Auto-immune disorders _____
- Psychiatric disorders _____
- Other _____
- Other _____

Have you ever had surgery before? If yes, what surgery did you have and when?

Surgery	When
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are you taking any prescription medications? Yes No

If so, list them below:

Medication	Dose	How often?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you taking any herbal, over-the-counter or alternative/complementary medications, vitamins or supplements? Yes No

If so, list them below:

Agent	Dose	How often?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any allergies to medications? Yes No

If yes, list them below:

Medication	What happens when you take it?
_____	_____
_____	_____
_____	_____
_____	_____

Social History

Do you consume soy products? Yes No
If yes, how much and what types? _____

Do you smoke? Yes No
If yes, how much per day? _____ For how long? _____

If you used to smoke, how much per day? _____ For how long? _____

When did you quit? _____

Do you drink alcohol? Yes No
If yes, how much and how often? _____

Review of Systems

Do you have any of the following?

- Easy bruising or bleeding
- Headaches
- Fatigue
- Loss of appetite
- Weight loss
- Chest pain
- Shortness of breath
- Nausea/vomiting
- Abdominal pain
- Skin rashes or changes
- NEW bone or joint pain(s)

Please explain any above checked boxes _____

