BREAST CARE CONSULTANTS OF NORTHERN VIRGINIA
Female Breast Heath 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 (i.e. birth control) incl. 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 ☐ Both
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 (incl. both your mother's and father's sides) been diagnosed with breast cancer?
☐ Yes ☐ No
If yes, who? _____ Age at diagnosis _____ ☐ Living ☐ Deceased
_____ Age at diagnosis _____ ☐ Living ☐ 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 bra 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? ☐ Yes ☐ No
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 _____