ANDOVER SURGICAL ASSOCIATES
BREAST HEALTH HISTORY

NAME _____ TODAY'S DATE _____

DATE OF BIRTH _____ AGE _____

Reason for today's visit _____

1) WHAT IS YOUR RACE? ____ Caucasian/ White ____ African-American/Black
____ Hispanic/Latina ____ Other

2) Does/Did your mother have breast cancer? Yes No Not Sure

3) Does/Did your daughter have breast cancer? Yes No Not Sure

4) Does/Did your sister(s) have breast cancer? Yes No Not Sure

5) Have you every had any of the following:

Abnormal Mammogram _____ Breast Cyst _____

Breast Pain _____ Nipple Discharge _____

Breast Infection _____ Breast Injury _____

6) Have you ever had a breast biopsy? Yes No

a. If yes, how many? _____

b. What was the diagnosis? _____ Invasive Breast Cancer
_____ Ductal Carcinoma In-Situ
_____ Lobular Carcinoma In-Situ
_____ Atypical Hyperplasia
_____ Other (fibrocystic disease, etc.)
_____ Not Sure

7) How old were you when you had your 1st period? _____

8) Have you ever been pregnant? Yes No

a. How many times? _____

b. # of deliveries (live births)? _____

c. How old were you at the time of your 1st live birth? _____

d. Did you ever breast feed? Dates: _____

9) Have you had a hysterectomy? Yes No

10) What stage of menopause are you in?

_____ Pre-menopausal (women whose periods follow a cycle)

_____ Peri-menopausal (women who have significant menstrual changes, or no period for 3 months or longer).

_____ Post-menopausal (women who have not had a natural, spontaneous period for 12 months or more)

Age at last menstrual period _____

11) Have you ever used hormones or been on birth control? Yes No