Breast Symptoms History Form

The Katherine M. Cyran M.D. Breast Center

Last name: _____First: _____MI ____ DOB: _____Age:_____

Race : _____ Any previous last names:_____

Email:_____

May we send results to your email? Y N Send a report to additional physician? N/Y _____

Current Breast Concern: _____

Medical History: Please list age or year to any that apply:

Last Menstrual Cycle: _____ Are You Pregnant? Y N Breast Implants? Y N Type and Year _____

Age First Menstruation: _____ # of Children Birthed: _____ Age 1st Full Term Pregnancy: _____ Currently/Recently Nursing? Y/N _____

Age Menopause: _____ Age Hysterectomy: _____ Ovaries Removed?: Y/N Height: _____ Weight: _____ Current Smoker? Y/N

Hormone Use: Estrogen/Progesterone/Both : Y/ N Currently? Y / N Previously? Y/N Duration: _____

Current Medications: None or List: _____

Allergies to Medications: None or List: _____

Other Medical Conditions: None or List: _____

Practice Self Breast Exam? Y/N Recent Weight Change? Y/N _____ Periods Regular? Y/N/n/a_____ IUD Currently? Y/N

Family History of breast cancer: check those that apply:

___ Unknown
___ No Family History
___ Aunt, grandmother, cousin (weak)
___ Mother, sister, **pos**t-menopausal (intermediate)
___ **Pre**-menopausal mother, sister **OR multiple pos**t-menopausal first-degree relatives (high)

Risk Factors: check all that apply:

___ Personal history of breast cancer
___ Personal history of ovarian cancer

Prior Breast History: R=right L=left B=both

Last mammogram (year): _____ Location: _____ Ultrasound (year): _____ R L B Location: _____

Biopsy (year): _____ R L B Results _____

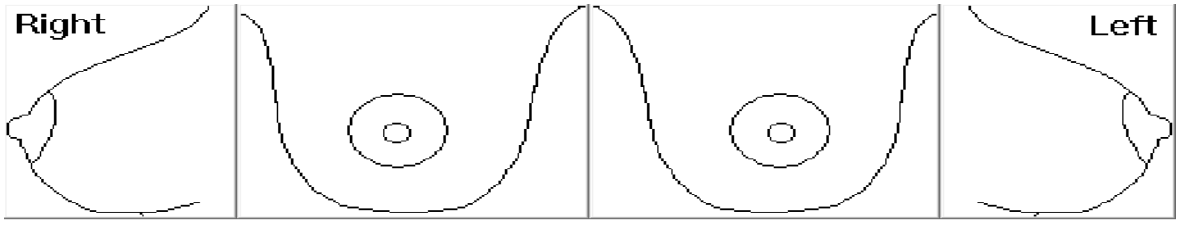
Lumpectomy(year):_____ R L B Mastectomy (year):_____ R L B Radiation Therapy (year):_____ R L B

Reduction (year):_____ R L B Other breast surgery: _____

Prior Breast Issues/ Evaluations or None:_____

Patient Signature: _____ Date: _____

For Tech Use:



Physician Notes: