LIMITED TO THE PRACTICE OF SURGERY

Patient: ____________________
Chart #: ____________________

BREAST DISEASE HISTORY
For
Drs. Cline, Waldenberg, Canale, Sturdivant and DiLalla

Reason for this visit: ____________________

Do you have breast pain, mass, discharge, etc?
Please explain: ____________________

Have you had mammograms?
When? ____________ Where? ____________________

Have you had a breast ultrasound?
When? ____________ Where? ____________________

Have you had previous surgery on your breast(s)?
When? ____________ Where? ____________________
Results ____________________

Have any of your relatives had breast cancer or ovarian cancer?
Who? ____________________ Age ________
Who? ____________________ Age ________
Who? ____________________ Age ________

When was your last menstrual period? ____________________
Was it normal in time and duration? ____________________

At what age did you start menstruating? ____________________

At what age did you stop menstruating (menopause)? ____________________

Have you taken birth control pills or hormones? ____________________
When and how long? ____________________

Have you ever been pregnant? ____________ How many times? ____________

How many children did you have? ____________ Their ages: ____________

Have you had a miscarriage or abortion? ____________________

Did you breast feed your child? ____________ How long? ____________

Is there anything else we should know that might be related to your breast history? ________ If so, please explain: ____________________

____________________ M.D.

____
Signature of Patient Date
OR Name of Person Completing Form if other than Patient.