Seacoast General Surgery, PC

BREAST HISTORY FORM

Date: _____ NAME: _____ Date of birth: ___/____/____

Primary Care Physician: _____
Where are your mammograms done? _____

Please fill out the below breast history as accurately as possible to complete your medical history.
If you are a MALE Just answer questions with an "* "

At what age did you start your periods: _____ Age of Menopause (if applicable): _____

Oral Contraceptive use: ____ Yes ____ No Years ago? _____

Did you ever take hormone replacement pills? ___ Yes ___No If yes, Date started: _____Stopped: ____

Number of pregnancies: _____ Number of live Births: _____ Age at first live birth: _____

Did you breastfeed any children: _____ Yes _____ No If Yes, How long: _____wks/months/yrs

Do you do monthly Self Exams: _____ Yes _____ No

*Nipple Discharge: Now: _____ Yes _____ No
Before: _____ Yes _____ No When:_____

*Breast pain: Now: _____ Yes _____ No

Before Periods only: _____ Yes _____ No

All the time: _____ Yes _____ No

*History of Breast Infection: _____ Yes _____ No When: _____
*History of breast injury/trauma: _____ Yes _____ No When: _____

*Family History of Breast Cancer: (Circle Applicable Family Member)

Mother Sister Maternal GM Paternal GM Maternal Aunts
Paternal Aunts None Other_____

*Family History of Ovarian Cancer: ___ Yes ___ No
*If YES please list family member _____

*Age of Family members' diagnosis: _____

*Personal History of Breast Cancer: _____ Yes _____ No Treatment:_____

MD Review: _____ Date: _____
Initials