171 Farenholt Avenue

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C#_____

BREAST SCREENING

Name_____ Today's Date_____
Birthdate_____
Please circle the appropriate answer for any of the following that apply to you:

YES / NO Family history of Breast Cancer. Relation to you:_____
Approximate age of diagnosis of cancer:_____

YES / NO Breast pain: Where:_____How often:_____
Started approximately when:_____

YES / NO Nipple discharge. How much:_____
How often:_____ Describe discharge:_____

YES / NO Personal history of breast problems. Type:_____

YES / NO Previous breast biopsies or surgeries. When:_____
By who:_____
Results: Cancerous/Benign/Other:_____

YES / NO Breast ultrasound. When:_____ Where:_____
Results:_____

YES / NO Mammogram. When:_____ Where:_____
Results:_____

YES / NO Are you currently pregnant? If yes, age of gestation:_____

Age of First pregnancy:_____ Number of pregnancies:_____

YES / NO Breastfed.

YES / NO Menopausal. Age of onset:_____

Current Hormonal medication/treatments:_____
Age of onset of first menstruation period:_____

Reviewed by:_____, ISC Staff