1. PAST MEDICAL HISTORY

- Do you have any medical conditions? (hypertension, diabetes) etc..

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

- Have you had any surgeries in the past? (Which ones and When?)

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

- Do you take any medications and which ones?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

2. PERSONAL HISTORY

- At what age did you start menstruating? ______ y.o.
- At what age did you undergo menopause? ______ y.o.
- How many pregnancies have you had? ______
- If applicable, at what age did you have your first completed pregnancy? _____ y.o.
- Did you ever take oral contraceptives? Y ___ N ___ For how many years? ______
- Did you ever take hormone replacement therapy? Y ___ N ___
  For how many years? _____
- Did you ever have high dose hormonal treatment (like IVF for example)? Y___
  N___

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3. FAMILY HISTORY

- Has anyone in your family been diagnosed with breast cancer? Y ___ N ___

- If yes, who in relation to you? At what age were they diagnosed?

________________________________________________________________________
________________________________________________________________________

- Has anyone in your family been diagnosed with ovarian cancer? Y ___ N ___

- If yes, who in relation to you? At what age were they diagnosed?

________________________________________________________________________
________________________________________________________________________

4. PAST BREAST HISTORY

- Have you had a breast biopsy in the past? Y ___ N ___

- If yes, when? What was the diagnosis?

________________________________________________________________________
________________________________________________________________________
Have you had breast surgery in the past? Y___ N___

If yes, when? For what diagnosis? And what was the type of surgery?

Have you had breast radiation in the past? Y___ N___

Do you have breast implants? Y___ N___

5. LAST BREAST IMAGING

When was your last breast imaging?

What was the type of breast imaging you had?

Mammogram ___ Tomosynthesis ___ Ultrasound___ MRI ___

What was the result?

(In this case if you have a copy of the report or digital copy of the exam, bring it to your appointment)
6. YOUR BREAST SYMPTOMS

- When did it appear?
- Do you have a mass? If yes, has it increased in size?
- Do you have pain?
- Do you have nipple discharge?
- Do you have skin changes?
- Do you see an asymmetry between your two breasts?