General Laparoscopic & Oncologic Surgery

Last Name: First Name: Date:___/___/___

PATIENT'S BREAST EXAMINATION

Please give the name of the Physician who referred you for your problem: ____________________
____

Please describe your breast problem: ____
____

How old were you when you had your first period? ___________________________________

How many pregnancies have you had, if any?____
How many live births? ____
If any, how many miscarriages? ______________________ Any abortions? ________________

How old were at the birth of your first child? ____

Did you breast feed your children? _____YES _____NO

Have you ever taken birth control pills (pills or Depo Provera shots?) _____YES _____NO
If yes, for how long? ____

Have you gone through menopause? If yes, explain ____________________________________
Are you taking, or have you taken hormone replacement? _____ YES _____NO
If yes, what have you taken, and for how long? _______________________________________

Do you have any nipple discharge? _____YES _____NO
If yes, please explain ____

Do you have any breast pain? _____YES _____NO
If yes, please explain ____

Do you perform self breast examinations? _____YES _____NO
If yes, are there any lumps you are concerned about? Please explain _______________________
____

Have you ever had a breast biopsy done? _____ YES _____NO
If yes, list date and location ____
What was the outcome of the biopsy? ____

Do you have any relatives with breast cancer? _____YES _____NO
Relationship ____
If yes, how old were they when diagnosed and what treatment was performed?
____