Brigham and Women's
Comprehensive Breast Health Center

Today's Date:_________ Age: ______ ***BP*** ____, ***P______, R______.***

Reason for Today's Visit:

Palpable Mass   Nipple discharge   Breast Pain

Abnormal Mammogram

Prior Breast Problems/ Biopsies:

Menstrual History

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

Last Menstrual Period_________ Age at Menopause ___________

Have you taken Birth Control Pills ______ If yes at what age did you start____ stop____.

Have you ever taken Estrogen Replacement Therapy ______ If yes for how long_______

Reproductive History

How many pregnancies have you had? __________

How many deliveries have you had? _______

Age at first delivery _____

Family Medical History:

Please list any significant family medical problems including history of breast, ovarian or other cancers

Current Medications:

Medication Allergies:

Past Medical History: Circle past and present medical conditions

Anemia	diabetes	high cholesterol	rheumatic fever
Anxiety	COPD	infections	seizures
Arthritis	emphysema	inflammatory bowel	stroke
Asthma	gout	disease	TB
Bladder infection	heart disease	kidney disease/stones	thyroid disease
Blood transfusion	heart murmur	obesity	ulcer/duodenal
Bleeding problems	hepatitis	pancreatitis	ulcer/gastric
Cancer	high blood	panic attacks	other_________
Depression	pressure	rashes	

Past Surgical Procedures:

SOCIAL HISTORY:

Occupation ___________ Do you live alone?___________________________

Do you smoke cigarettes? Yes No Packs per day ______ How long _______

If you drink alcohol, how many glasses per week___________ ( ) I do not drink alcohol.

Pain: Do you experience pain as part of your daily life? Yes No

If yes describe the location, onset, duration and characteristics (ache, burn, throb, sharp)

If yes on a scale from 1-10, 10 being the worst rate your pain _____

If yes how do you treat the pain? ____.

Domestic Violence:

Have you ever felt unsafe or been afraid of anyone? Yes____, No____.

Has anyone ever hurt or threatened to hurt you or someone else that you care about? Yes___, No ____.

Notes:

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I have reviewed this document with the patient.

DATE ___________________ SIGNATURE ___________________________ CLINICIAN ID___________