TEXAS BREAST SPECIALISTS

MRN: _____

# Breast Patient History Questionnaire

Today's Date: _____ Patient Name: _____ Date of Birth: _____
Last First Middle or Maiden

## Breast History

Date of last Mammogram: _____ Results: _____

Current Bra Size: _____ Do you have breast implants? ☐ Yes ☐ No

Do you know how to perform breast self-exam? ☐ Yes ☐ No

How often do you perform breast self-exam? ☐ Monthly ☐ Every few months ☐ Few times a year ☐ Other: _____

| Past Breast History | YES | Which Side? | Date of Diagnosis/Procedure | Treatment or Result |
|---|---|---|---|---|
| Breast Cancer | ☐ | ☐ R ☐ L | | |
| Breast Cyst | ☐ | ☐ R ☐ L | | |
| Breast Biopsy | ☐ | ☐ R ☐ L | | ☐ Atypical Hyperlasia<br>☐ Lobular Carcinoma in Situ (LCIS)<br>☐ Ductal Carcinoma in Situ (DCIS)<br>☐ Invasive Cancer<br>☐ Other: |
| Other: | ☐ | ☐ R ☐ L | | |

## Reproductive History

Date of last menstrual period: _____ Number of pregnancies: _____

Age at last period (menopause): _____ Number of live births: _____

Age at first menstrual period: _____ Age at first live birth: _____

Do you or have you taken hormones replacement therapy (HRT) or birth control pills? ☐ Yes ☐ No

↳ If yes, what type and how long did you use them?

| Name/Type | Length of Time |
|---|---|
| | |
| | |
| | |

Have you had your uterus removed? ☐ Yes ☐ No If Yes, Age: _____

Have you had your ovaries removed? ☐ Yes ☐ No If Yes, Age: _____

↳ If Yes, Which ovary was removed? ☐ Both ☐ Right Ovary ☐ Left Ovary

## General Questions

Have you ever had any problems with anesthesia? ☐ Yes ☐ No If Yes, please describe: _____

Can you walk a block or climb a flight of stairs without getting short of breath? ☐ Yes ☐ No

I certify that the above information is accurate.

Signature of Patient/Legally Authorized Representative: _____ Date: _____


Please return completed form to the appropriate physician's office.