



Providence Breast Health Center
6600 Fish Pond Road, Suite 104
Waco, Texas 76710
(254)235-3535

Date _____

BREAST HEALTH HISTORY

Name _____ SS# _____
 Address _____ Home Phone _____
 _____ Cell Phone _____
 Age _____ Date of Birth _____ Race _____ Work Phone _____
 1st Mammogram ____ Yes ____ No. If no, where and when was your prior mammogram?
 Date _____ Where _____
 Age of 1st menstrual period _____ Age of last menstrual period (Menopause) _____

	NO	YES	WHICH BREAST?	HOW LONG?
Do you have any NEW breast lumps?	_____	_____	_____	_____
Breast pain or tenderness?	_____	_____	_____	_____
Nipple discharge (color)?	_____	_____	_____	_____
Nipple retraction (pulling inward)?	_____	_____	_____	_____
Crusting or redness of nipple?	_____	_____	_____	_____
Skin puckering or dimpling?	_____	_____	_____	_____
Redness or swelling?	_____	_____	_____	_____
Other breast problems?	_____			

Are you currently taking any of the following medications(s):

	YES	NAME OF MEDICATION	HOW LONG?
Hormone replacement therapy	_____	_____	_____
Vaginal creams with hormones	_____	_____	_____
Birth control pills	_____	_____	_____

Date of last physical breast examination by Physician— Name _____ Date _____

Have any of your blood relatives been diagnosed with breast cancer? ____ Yes ____ No
 _____ (Relationship) _____ (age of diagnosis)
 _____ (Relationship) _____ (age of diagnosis)
 _____ (Relationship) _____ (age of diagnosis)

Have any of your blood relatives been diagnosed with ovarian cancer? ____ Yes ____ No
 Have any of your blood relatives been diagnosed with any other cancer? ____ Yes ____ No
 Are you BRCA gene 1 or 2 positive? ____ Yes ____ No

Weight gain since last mammo? ____ Yes ____ No How much? _____
 Weight loss since last mammo? ____ Yes ____ No How much? _____
 Adhesive allergy? ____ Yes ____ No
 Latex allergy? ____ Yes ____ No

Have you ever had any of the following procedures?

	NO	YES	WHICH BREAST?	WHEN?
Fine needle aspirations of cysts?	_____	_____	_____	_____
Fine needle aspirations of breast lump?	_____	_____	_____	_____

Have you had any of the following breast surgeries?

	NO	YES	WHICH BREAST?	WHEN?
Benign breast surgery	_____	_____	_____	_____
Atypical breast surgery	_____	_____	_____	_____
Cancer breast surgery	_____	_____	_____	_____
Mastectomy for breast cancer	_____	_____	_____	_____
Breast reconstruction	_____	_____	_____	_____
Breast implants to enlarge breasts	_____	_____	_____	_____

If you have had breast cancer, did you receive any of the following treatments?

	NO	YES	WHEN?
Radiation therapy	_____	_____	_____
Chemotherapy	_____	_____	_____

Have you had any other type of cancer? _____ Yes _____ No

If yes what type? _____ When? _____

What treatments did you receive? _____ When? _____

Physician(s) you would like your report sent to:

1. _____ Address _____

2. _____ Address _____

I have been instructed regarding the importance of breast self examination, yearly clinical exam by a physician and routine mammography as part of my plan for breast health.

Patient's Signature _____

TO BE COMPLETED BY TECHNOLOGIST ONLY:

Comments: _____

Signature _____

