

Comprehensive Breast Center – Medical, Social, & Family History Form

Name: _____ Date of Birth: _____

Past Medical History (Please darken bubble completely – indicate only Yes response)					
Acute Myocardial Infarction (Heart Attack)	<input type="radio"/> Yes	<input type="radio"/> No	Myocardial Infarction	<input type="radio"/> Yes	<input type="radio"/> No
Atrial Fibrillation (Irregular Heartbeat)	<input type="radio"/> Yes	<input type="radio"/> No	Multiple Sclerosis	<input type="radio"/> Yes	<input type="radio"/> No
Carotid Stenosis (Blockage In Neck)	<input type="radio"/> Yes	<input type="radio"/> No	Obesity	<input type="radio"/> Yes	<input type="radio"/> No
Cardiomyopathy (Enlarged Heart)	<input type="radio"/> Yes	<input type="radio"/> No	Ovarian Mass	<input type="radio"/> Yes	<input type="radio"/> No
Asthma	<input type="radio"/> Yes	<input type="radio"/> No	Parkinsons Disease	<input type="radio"/> Yes	<input type="radio"/> No
Anxiety	<input type="radio"/> Yes	<input type="radio"/> No	Renal Insufficiency, Chronic-Kidney	<input type="radio"/> Yes	<input type="radio"/> No
Blood Dyscrasias (Blood Clotting Disorder)	<input type="radio"/> Yes	<input type="radio"/> No	Rheumatic Heart Disease	<input type="radio"/> Yes	<input type="radio"/> No
Cirrhosis	<input type="radio"/> Yes	<input type="radio"/> No	Sleep Apnea	<input type="radio"/> Yes	<input type="radio"/> No
Diabetes Mellitus	<input type="radio"/> Yes	<input type="radio"/> No	Seizures	<input type="radio"/> Yes	<input type="radio"/> No
Emphysema	<input type="radio"/> Yes	<input type="radio"/> No	Stroke	<input type="radio"/> Yes	<input type="radio"/> No
Family History Of Colon Cancer	<input type="radio"/> Yes	<input type="radio"/> No	Cancer, Breast	<input type="radio"/> Yes	<input type="radio"/> No
Family History Of Coronary Artery Disease	<input type="radio"/> Yes	<input type="radio"/> No	Cancer, Colon	<input type="radio"/> Yes	<input type="radio"/> No
Heart Murmur (Mitral Valve Prolapse)	<input type="radio"/> Yes	<input type="radio"/> No	Cancer, Lung	<input type="radio"/> Yes	<input type="radio"/> No
Hypercholesterolemia (High Cholesterol)	<input type="radio"/> Yes	<input type="radio"/> No	Cancer, Melanoma	<input type="radio"/> Yes	<input type="radio"/> No
Hypertension	<input type="radio"/> Yes	<input type="radio"/> No	Cancer, Lymphoma	<input type="radio"/> Yes	<input type="radio"/> No
Hepatitis C	<input type="radio"/> Yes	<input type="radio"/> No	Cancer, Ovarian	<input type="radio"/> Yes	<input type="radio"/> No
Hyperthyroidism (High Thyroid)	<input type="radio"/> Yes	<input type="radio"/> No	Cancer, Renal Cell	<input type="radio"/> Yes	<input type="radio"/> No
Hypothyroidism (Low Thyroid)	<input type="radio"/> Yes	<input type="radio"/> No	Cancer, Skin	<input type="radio"/> Yes	<input type="radio"/> No
HIV Positive	<input type="radio"/> Yes	<input type="radio"/> No	Cancer, Stomach	<input type="radio"/> Yes	<input type="radio"/> No
			Cancer, Thyroid	<input type="radio"/> Yes	<input type="radio"/> No
Surgical History					
Appendectomy (Appendix Removed)	<input type="radio"/> Yes	<input type="radio"/> No	Breast Biopsy	<input type="radio"/> Yes	<input type="radio"/> No
Cholecystectomy (Gallbladder Removed)	<input type="radio"/> Yes	<input type="radio"/> No	Lumpectomy	<input type="radio"/> Yes	<input type="radio"/> No
Aortic Valve Replacement	<input type="radio"/> Yes	<input type="radio"/> No	Breast Implant	<input type="radio"/> Yes	<input type="radio"/> No
Coronary Artery Bypass Graft	<input type="radio"/> Yes	<input type="radio"/> No	Breast Reconstruction	<input type="radio"/> Yes	<input type="radio"/> No
Aortobifemoral Bypass	<input type="radio"/> Yes	<input type="radio"/> No	Lymph Node Resection	<input type="radio"/> Yes	<input type="radio"/> No
Carotid Endarterectomy	<input type="radio"/> Yes	<input type="radio"/> No	Mastectomy (Breast Removed)	<input type="radio"/> Yes	<input type="radio"/> No
Pacemaker, Cardiac	<input type="radio"/> Yes	<input type="radio"/> No	Nephrectomy (Kidney Removed)	<input type="radio"/> Yes	<input type="radio"/> No
Lung Resection	<input type="radio"/> Yes	<input type="radio"/> No	Thyroidectomy (Thyroid Removed)	<input type="radio"/> Yes	<input type="radio"/> No
Bladder Surgery	<input type="radio"/> Yes	<input type="radio"/> No	Transplant, Kidney	<input type="radio"/> Yes	<input type="radio"/> No
Brain Aneurysm	<input type="radio"/> Yes	<input type="radio"/> No	Hysterectomy, Partial	<input type="radio"/> Yes	<input type="radio"/> No
			Hysterectomy, Total With Bilateral Salpingo-Oophorectomy (BSO)	<input type="radio"/> Yes	<input type="radio"/> No

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General/Constitutional			Breast		
Bone Pain	<input type="radio"/> Yes	<input type="radio"/> No	Bloody Nipple Discharge	<input type="radio"/> Yes	<input type="radio"/> No
Fatigue	<input type="radio"/> Yes	<input type="radio"/> No	Breast Lump	<input type="radio"/> Yes	<input type="radio"/> No
Fever	<input type="radio"/> Yes	<input type="radio"/> No	Breast Pain	<input type="radio"/> Yes	<input type="radio"/> No
Night Sweats	<input type="radio"/> Yes	<input type="radio"/> No	Breast Swelling	<input type="radio"/> Yes	<input type="radio"/> No
New Onset Headache	<input type="radio"/> Yes	<input type="radio"/> No	Cracked Nipple	<input type="radio"/> Yes	<input type="radio"/> No
Gastrointestinal			Nipple Discharge	<input type="radio"/> Yes	<input type="radio"/> No
Blood In Stool	<input type="radio"/> Yes	<input type="radio"/> No	Nipple Retraction	<input type="radio"/> Yes	<input type="radio"/> No
Ophthalmologic			Red Skin	<input type="radio"/> Yes	<input type="radio"/> No
Blurred Vision	<input type="radio"/> Yes	<input type="radio"/> No	Skin Dimpling	<input type="radio"/> Yes	<input type="radio"/> No
Neurologic			Hematology		
Dizziness	<input type="radio"/> Yes	<input type="radio"/> No	Easy Bruising	<input type="radio"/> Yes	<input type="radio"/> No
Tingling/Numbness	<input type="radio"/> Yes	<input type="radio"/> No	HIV	<input type="radio"/> Yes	<input type="radio"/> No
Difficulty Speaking	<input type="radio"/> Yes	<input type="radio"/> No	Prolonged Bleeding	<input type="radio"/> Yes	<input type="radio"/> No
Seizures	<input type="radio"/> Yes	<input type="radio"/> No	Recent Transfusion	<input type="radio"/> Yes	<input type="radio"/> No
Fainting	<input type="radio"/> Yes	<input type="radio"/> No	Weakness	<input type="radio"/> Yes	<input type="radio"/> No
Cardiovascular			Respiratory		
Heart Attack	<input type="radio"/> Yes	<input type="radio"/> No	Blood In Sputum	<input type="radio"/> Yes	<input type="radio"/> No
Heart Murmur	<input type="radio"/> Yes	<input type="radio"/> No	Cough	<input type="radio"/> Yes	<input type="radio"/> No
Swelling In Legs	<input type="radio"/> Yes	<input type="radio"/> No	Shortness Of Breath At Rest	<input type="radio"/> Yes	<input type="radio"/> No
Chest Pain At Rest	<input type="radio"/> Yes	<input type="radio"/> No	Shortness Of Breath With Exertion	<input type="radio"/> Yes	<input type="radio"/> No
Chest Pain With Exertion	<input type="radio"/> Yes	<input type="radio"/> No	Wheezing	<input type="radio"/> Yes	<input type="radio"/> No
Irregular Heartbeat	<input type="radio"/> Yes	<input type="radio"/> No	Social History		
			Tobacco Use	<input type="radio"/> Yes	<input type="radio"/> No

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OB / GYN History	
How old were you when you started your period?	
How old were you when you experienced menopause?	
How many full term pregnancies have you had?	
How many living children?	
If you have taken oral contraceptives, how many years did you use them?	
If you have taken fertility treatments, how many years did you use them?	
If you have used hormone replacement therapy, how many years?	
Family History	
Who in your family has had breast cancer?	
Who in your family has ovarian cancer?	
Are you an Ashkenazi Jewish?	<input type="radio"/> Yes <input type="radio"/> No
Allergies	
What medications are you allergic to?	None <input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa <input type="checkbox"/> Other
Current Medications with Dosages	
Any other relevant medical, surgical, social or family history not listed above?	