



Somerset Surgical Specialists

Breast History and Risk Assessment Form

Patient Name: _____

Date: _____

Height: _____ Weight: _____

DOB: _____

Race: _____

Personal Breast History

Location

Have you ever had breast cancer? Y N If yes, what treatment did you have? _____

Do you have a lump that you can feel? Y N Right Left

Do you have a lump that your doctor can feel? Y N Right Left

Do you have nipple discharge? Y N

Are you BRCA positive? (genetic test) Y N

Do you have breast pain? Y N Right Left

Have you ever had a previous mammogram? Y N What years? _____ Results? _____

Have you ever had a previous ultrasound? Y N What years? _____ Results? _____

Have you ever had previous breast MRI? Y N What years? _____ Results? _____

Have you ever had a previous breast biopsy? Y N Right Left When? _____ Results? _____

Have you ever had a breast cyst aspirated? Y N Right Left When? _____

Do you have regular periods? Y N Date of last menstrual period: _____

Personal and Family Cancer History:

Have YOU or any of your family members ever been diagnosed with any of the following?

Breast Cancer Y N What Relation? _____ Mother or father's side? _____ Age at diagnosis _____ Present Age _____

Colon Cancer Y N What Relation? _____ Mother or father's side? _____ Age at diagnosis _____ Present Age _____

Ovarian Cancer Y N What Relation? _____ Mother or father's side? _____ Age at diagnosis _____ Present Age _____

Uterine Cancer Y N What Relation? _____ Mother or father's side? _____ Age at diagnosis _____ Present Age _____

Radiation History:

Have you ever received radiation to your chest wall? (e.g., Hodgkin's therapy, repeated fluoroscopies) Y N

Alcohol History: Do you drink alcohol? Y N How many drinks per week? _____

Tobacco History: Have you ever smoked? Y N Age started: _____ Age when quit: _____ Packs per day: _____

Sun Exposure History: Frequent sun exposure (past or present)? Y N Frequent sunburns? Y N



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Reproductive History:

Age at first period _____ Age at menopause _____

Have you ever been pregnant? Y N If yes, how many times? _____ If yes, have you ever had preeclampsia? Y N

(if not, skip down to the Hormonal Drug History Section)

Please fill in the length of each pregnancy by the # of weeks: (a full-term pregnancy is 40 weeks)

Pregnancy

1 st	2 nd	3 rd	4 th	5 th	6 th

How old were you at the end of each pregnancy?

What was the outcome of each pregnancy?

Live Birth: How many weeks?					
Multiple Birth: How many weeks?					
Still Birth: How many weeks?					
Miscarriage: How many weeks?					

D&C after fetus died: How many weeks?

Abortion: How many weeks?

Ectopic Pregnancy: How many weeks?

Did you breastfeed? Yes No (Please Circle) How many weeks?

Hormonal Drug History:

Have you ever used a hormone replacement? (e.g., estrogen, progesterone, Provera, Premarin) Y N

Drug Name: _____ How long used? _____ Age when started: _____

Have you ever used fertility drugs?(e.g., Clomid, Pergonal) Y N Age when started: _____

Drug Name: _____ How long used? _____

Did you or your mother ever use DES (Diethylstilbestrol)? Y N When? _____

Contraceptive History:

Have you ever used any of the following?

Birth Control Pills? Y N

Drug Name: _____ Age when started: _____ Age when stopped: _____ Reason for discontinuing? _____

Drug Name: _____ Age when started: _____ Age when stopped: _____ Reason for discontinuing? _____



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Drug Name: _____ Age when started: _____ Age when stopped: _____ Reason for discontinuing? _____

Contraceptive injectable and/or device? (e.g., Nueva Ring, Norplant, Depo-Provera, IUD, Patch) Y N Age when started: _____

Drug Name: _____ How long used? _____