Document Type: Forms/Other
Subject: Breast Center - Personal History

Breast Care Center Personal History Form

☐ Methodist Hospital ☐ Methodist Jennie Edmundson Hospital

PERSONAL HISTORY

Age at First Menstrual Period: _____ Date of Last Period: _____

Regular Periods: ☐ Yes ☐ No _____

Age at Menopause: _____ ☐ Natural ☐ Surgical Hysterectomy / Oophorectomy

Have you ever taken birth control pills? ☐ Yes ☐ No Type:_____ # of Years: _____

Progesterone, Estrogen, Fertility Txs or other hormone therapy? ☐ Yes, current ☐ Yes, in past ☐ No, never

Current Bra Size:_____ If yes, Type:_____ # of Years: _____

Breast Enlargement: ☐ Yes ☐ No When:_____

Breast Reduction: ☐ Yes ☐ No When:_____

Age at First Live Birth: _____ Number of: Pregnancies _____ Full-term Pregnancies _____ Miscarriages _____

Did you Breast Feed? ☐ Yes ☐ No How long?_____

Previous Mammogram: ☐ Yes ☐ No If Yes, When?_____ Where?_____

Previous Breast Procedures:_____
(lumpectomy, mastectomy, implants)

Date _____ ☐ R ☐ L ☐ B Where:_____

Personal history of breast cancer? ☐ Yes ☐ No Age at Diagnosis: _____

Year of Diagnosis: _____

Treatments:_____

Surgery: ☐ Mastectomy ☐ Lumpectomy ☐ Breast: ☐ R ☐ L ☐ Bilateral

☐ Reconstruction: ☐ Yes ☐ No Type:_____

Dr. _____ Date:_____

Personal history of ovarian cancer? ☐ Yes ☐ No Age at Diagnosis: _____

FAMILY HISTORY OF CANCER

M = Maternal P = Paternal

Breast Cancer and Age of Diagnosis: Mother_____, Sister_____, Aunt_____, Grandmother_____, Cousin_____, Other_____

Other Family History of Cancer: _____

_____

SOCIAL HISTORY

☐ Married ☐ Single ☐ Divorced ☐ Widowed Race:_____

Children: ☐ Yes ☐ No How many?_____

Occupation: _____ Employed or Retired?_____

Alcohol use: ☐ Yes ☐ No How much:_____ (including beer and wine)

Tobacco use: ☐ Yes ☐ No Type: _____ (including vaping)

Caffeine use: ☐ Yes ☐ No How much:_____ (coffee, tea, cola, chocolate, medication)

Drug use: ☐ Yes ☐ No How much:_____ (marijuana, LSD, speed, heroin, others)

Any financial concerns related to your breast care? ☐ Yes ☐ No

Patient Label

NAME:_____DOB:_____

FIN:_____MRN:_____

PERMANENT PART OF MEDICAL RECORD