NEW BREAST PATIENT INFORMATION

Patient Name: _____ **Today's date**: _____

Date of Birth: _____ **Age**:_____

Reason you are seeing the Doctor today:

_____

_____

_____

Past Breast Surgeries/Biopsies:

_____

_____

_____

(PLEASE CIRCLE)

ANY BREAST PROBLEMS?	ANY BREAST LUMPS?	ANY BREAST PAIN?	ANY NIPPLE DISCHARGE?
YES NO	YES NO IF YES, RIGHT OR LEFT BREAST	YES NO	YES NO

Age of First Menstrual Cycle:_____ **Date of Last Menstrual Cycle**:_____

Age Menopause began: _____

Are you currently taking Birth Control Pills or hormone replacement? (PLEASE CIRCLE) YES NO
If yes, for how long: _____

Your age at the time of your first childbirth: _____**Number of live births**: _____

Did you breast feed? YES NO If yes, how many children and for how long? _____

Any family members with breast cancer? YES NO If yes, please circle one or both - Mother or Father's side

_____

_____

_____

_____