PATIENT MEDICAL RISK HISTORY SHEET

Date: _____

Last name: _____ First: _____ MI: _____
Address: _____ City: _____ State: _____
Zip: _____ Birth Date: _____/_____/_____
Gender Identity: Female ☐ Male ☐ Transgender: ☐
Cell Phone: (____) _____ - _____ Daytime Phone (____) _____ - _____ x_____
Email Address: _____
Referring Physician: _____
Previous Mammo Date and Location: _____
Your name if different: _____
Height: _____ Weight: _____ Weight loss/gain of more than 10lbs in the last year? Yes ☐ No ☐

Lump/Thickening	Yes ☐	No ☐	Rt or Lt
Pain (chronic or new)	Yes ☐	No ☐	Rt or Lt
Nipple Discharge	Yes ☐	No ☐	Rt or Lt
Skin Changes	Yes ☐	No ☐	Rt or Lt
Pregnant or Lactating	Yes ☐	No ☐	Rt or Lt

Patient History (inset age)
1st Menstruation _____ Menopause _____ Hysterectomy _____ Ovaries Removed Yes ☐ No ☐
1st Live Birth _____ # of Children _____ # Breast Fed _____ Never Pregnant
Hormone use Yes ☐ No ☐ If yes, How long? _____
Hormone Contraceptives _____ Estrogen _____ Progesterone _____
Tamoxifen/Arimidex _____ Started/Finished _____ Still using _____

Have you had any breast surgery? (Mark all that apply) Yes No

Procedure:		Where:	When:	Results:
___ Biopsies	RT ☐ LT ☐	_____	_____	_____
___Lumpectomy	RT ☐ LT ☐	_____	_____	_____
___Mastectomy	RT ☐ LT ☐	_____	_____	_____
___Reduction	RT ☐ LT ☐	_____		
___Implants	RT ☐ LT ☐	_____		

Saline ☐ Silicone ☐ Pre-Pectoral ☐ Retro-Pectoral ☐

Have you or anyone in your family been diagnosed with breast cancer? Yes ☐ No ☐
Who and ages: _____
Have you or anyone in your family been diagnosed with ovarian cancer? Yes ☐ No ☐
Who and ages: _____
Genetic Testing? Yes ☐ No ☐ Results: _____ Ashkenazi Heritage? Yes ☐ No ☐
Have you had cancer of any type? Yes No
Chemotherapy? Yes ☐ No ☐ Radiation therapy to chest or breast? Yes ☐ No ☐

Patient Signature: _____ Date: _____