

PATIENT'S CLINICAL INFORMATION

Your Name: _____ Your Age: _____ Date: _____

Do you have any of the following problems? If yes, state location:

Yes No A breast lump or mass that you feel: _____

Yes No An abnormal mammogram: _____

Yes No Nipple discharge or skin changes: _____

Yes No Enlarged lymph nodes: _____

Yes No Tenderness: _____

Yes No Other breast problems: _____

How long have you noticed the problem? _____

Is there anyone in your family who has had breast cancer? _____

If yes, who and at what age? _____

Are there other cancers in your family history? _____

How many children have you had? _____ Did you breastfeed any of them? _____

Your age when you first gave birth? _____

Do you take hormones? Yes No

Have you had any previous breast surgery? Yes No

If yes, for how long? _____

If so, please explain: _____

If no, did you take them in the past? Yes No

If yes, for how long? _____

Do you have:

weight loss

high blood pressure

abdominal swelling

diabetes

heart disease

emotional disorders

lung problems

other medical conditions

What medications do you take? _____

What other surgery have you had? _____

Are you allergic to any drugs? _____

Do you smoke or drink? Yes No