

The Center for Breast Health 

BREAST HEALTH INTAKE FORM

Name: _____ Age: _____ Race: _____
Are you of Ashkenazi Jewish heritage?
Yes No

Who referred you to Dr. Duchini's office today? _____

Name of your family doctor: _____

Name of your OB/GYN: _____

Reason for your visit today:

Circle any of the following if they apply:

Can you feel, or did your doctor feel, a breast mass? Yes No

If yes, which breast is it in? Right Left Both

How long has it been there? _____

Do you have any nipple discharge? Yes No

If yes, which nipple is it from? Right Left Both

How long has it been going on? _____

What color is it? Clear Bloody Green Yellow Milky Brown

Does it come out all by itself or only when you squeeze your nipple? _____ by itself
_____ when I squeeze

Do you have any breast pain? Yes No

If yes, which breast is it in? Right Left Both

Does it get worse around your periods? Yes No

When did it start? _____

How old were you when you began having periods? _____ years old

Are you still having periods? Yes No

If yes, when was your last period? _____

If no, how old were you when you went through menopause? _____

Did you have a hysterectomy (uterus taken out)? Yes No

If yes, how old were you at the time? _____ years old

Why was it removed? _____

Do you still have your ovaries? Yes No

Have you ever taken birth control pills? Yes No

If yes, how long? _____ years

Are you still taking it? Yes No

If no, how long ago did you stop? _____ years

Have you ever taken hormone replacement therapy? Yes No

If yes, how long? _____ years

Are you still taking it? Yes No

If no, how long ago did you stop? _____ years

Have you ever been pregnant? Yes No
If yes, how many times? _____
How many children do you have? _____
How old were you when you gave birth to your 1st child? _____ years old
Did you breast feed? Yes No
If yes, for how long? _____

Have you ever had any of the following:

Breast trauma Yes No
Breast Abscess Yes No
Breast Infection Yes No

Have you ever had a breast biopsy? Yes No

If yes, which breast? Right Left
When? _____ Where was it done? _____
What was the result? _____

When was your last mammogram? _____

Where was it done? _____

Have you ever had an abnormal mammogram, ultrasound, or MRI of the breast? Yes No

Did you ever have breast cancer? Yes No

If yes, when? _____
Which breast? Right Left
Did you have chemotherapy? Yes No
Did you have radiation? Yes No

Did any of your family members ever have breast cancer? Yes No

If yes, how old were they when they were first diagnosed?
Who? _____ Age at diagnosis _____
_____ Age at diagnosis _____
_____ Age at diagnosis _____

Did any of your family members have any of these other types of cancer? If so, who?

Ovarian? _____ Age at diagnosis _____
Colon? _____ Age at diagnosis _____
Thyroid? _____ Age at diagnosis _____
Prostate? _____ Age at diagnosis _____
Pancreas? _____ Age at diagnosis _____
Melanoma? _____ Age at diagnosis _____
Other types of cancer? _____ Age at diagnosis _____

Do you drink caffeinated drinks? (coffee, tea, cola, mountain dew, chocolate)

Yes No If yes, how much? _____

Do you use soy products? Yes No If yes, how much? _____

Do you smoke? Yes No

If yes, how much? _____ For how long? _____

If you used to smoke:

How much? _____ how long? _____ when did you quit? _____

Do you drink alcohol? Yes No

If yes, how much? _____

What is your current Bra & Cup size? _____

