Select Surgical

1. Have you had any of the following breast changes in the last 3 month? (Check all that apply)

	Both	Left	Right
Lump	☐	☐	☐
Nipple discharge	☐	☐	☐
Pain	☐	☐	☐
Other	☐	☐	☐

No changes ☐

2. When was your last mammogram?

Date: _____/_____ (month/year)

Location: _____

☐ I never had a mammogram

3. Have you ever been diagnosed with breast cancer?

☐ No

☐ Left breast ☐ Right breast ☐ both breasts

Date of diagnosis: _____

4. Have you had any of the following breast procedures? (Check all that apply)

	Left	Right	Both
Fine needle or cyst aspiration	☐	☐	☐
Biopsy	☐	☐	☐
Lumpectomy	☐	☐	☐
Mastectomy	☐	☐	☐
Radiation therapy	☐	☐	☐
Breast reconstruction	☐	☐	☐
Breast reduction	☐	☐	☐
Breast implants	☐	☐	☐

5. Have any blood relatives been diagnosed with breast cancer?

Mother: ☐ No ☐ Yes ☐ unknown

Sister: ☐ No ☐ Yes ☐ 2 or more ☐ unknown

Daughter: ☐ No ☐ Yes ☐ 2 or more ☐ unknown

IF YES: Were any diagnosed before age 50?

☐ No ☐ One ☐ 2 or more ☐ unknown

6. Have any blood relatives been diagnosed with ovarian cancer?

Mother: ☐ No ☐ Yes ☐ unknown

Sister: ☐ No ☐ Yes ☐ 2 or more ☐ unknown

Daughter: ☐ No ☐ Yes ☐ 2 or more ☐ unknown

IF YES: Were any diagnosed before age 50?

☐ No ☐ One ☐ 2 or more ☐ unknown

7. Are you currently using any of the following?

☐ No ☐ Yes **Hormone Replacement Therapy** (Including pills, patches or cream)

☐ No ☐ Yes **Tamoxifen** (also called Nolvadex, Istubal, Valodex)

☐ No ☐ Yes **Aromatase Inhibitors** (such as Anastrozole/Arimidex or Letrozole/Famara or Exemestane/ Aromasin)

☐ No ☐ Yes **Birth Control** (pills, patches, implants)

8. How old were you when you had your first period? _____

9. Have your menstrual periods stopped permanently?

☐ No Date of last period _____

☐ Yes, natural menopause

☐ Yes, but have them now from taking hormones

☐ Yes, surgical procedure

☐ Not sure

IF YES, age of last period: _____

10. Have you ever been pregnant? ☐ No ☐ Yes

# of pregnancies: _____

# of births: _____

11. How old were you when your FIRST child was born? ____ **Years old**

12. How old were you when your LAST child was born? _____ **Years old**

13. Did you breast feed? ☐ No ☐ Yes

IF YES: how long? _____

14. What is your daily caffeine intake_____?

15. What is your current BRA size? _____

Patient name: _____ DOB: _____