The Breast Clinic
918 Mar Walt Drive
Ft. Walton Beach, FL 32547
(850) 863-2006

DATE: _____

Medical Record #: _____

Referring Dr.: _____

Referring Dr. Fax #: _____

NAME: _____ _____ _____
Last First MI

DATE OF BIRTH: _____ AGE: _____

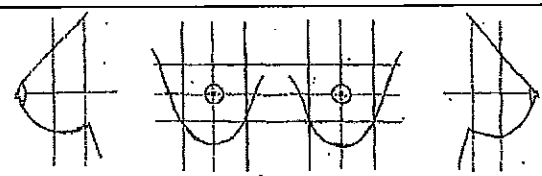
1. Are you **PREGNANT** now or is there a possibility that you could be pregnant? ☐ YES ☐ NO
2. How many children have you had? _____ How old were you when you had your first child? _____
3. Have you had a prior mammogram? ☐ YES ☐ NO IF YES, when? _____ and where? _____
4. Are you having any breast problems **NOW**? ☐ YES ☐ NO **IF YES**, mark the problem(s) below.
   a. Distinct lumps in either breast? ☐ Right ☐ Left
   b. Lumpiness (fibrocystic changes)? ☐ Right ☐ Left TECH INITIALS _____
   c. Discomfort, pain or soreness? ☐ Right ☐ Left
   d. Discharge from nipple? ☐ Right ☐ Left How long and what color? _____
5. Are you taking **Hormones**? ☐ YES ☐ NO If YES, for how long? _____
6. Have **YOU** had cancer of the: ☐ None ☐ Breast ☐ Uterus ☐ Ovaries ☐ Other _____
7. Do you have a **FAMILY HISTORY** of breast cancer? ☐ YES ☐ NO **IF YES,** please fill in boxes below.

☐ Mother	☐ Sister	☐ Daughter	☐ Grandmother	☐ Aunt	☐ Cousin
@ Age_____	@ Age_____	@ Age_____	@ Age_____	@ Age_____	@ Age_____

8. Please mark if **YOU** have previously had any of the Breast Procedures below. ☐ NONE
   a. **Needle Biopsy** ☐ Right ☐ Left When? _____ b. **Surgical Biopsy** (not cancer) ☐ Right ☐ Left When? _____
   c. **Cyst Aspiration** ☐ Right ☐ Left When? _____ d. **Implants** ☐ Right ☐ Left When? _____
   e. **Reduction** ☐ Right ☐ Left When? _____ f. **Lumpectomy (Cancer)** ☐ Right ☐ Left When? _____
   g. **Mastectomy** ☐ Right ☐ Left When? _____ h. **Radiation** ☐ Right ☐ Left When? _____

X PATIENT SIGNATURE: _____

I hereby declare that the information provided in this form is true and complete to the best of my knowledge.

For Office Use Only Tech Comments:	 Right Breast Left Breast

Smoke? ____ How many cigarettes per day? ____ How long have you or did you smoke?_____ Still smoking?_____ Want to Quit? _____ Have you tried to quit in the past?_____ Are you using nicotine patches, gum, or other medications to quit?

Drink alcohol? Never____ Occasional _____ How many servings per week? _____

How many servings per day of coffee_____ tea_____sodas_____water_____

What do you do for exercise? _____
How many hours per week? _____
Do you follow a particular diet?_____

Gained or lost weight in the past 6 months? _____ How much?_____
Intentional?_____

Date of your last: Bone Density _____ Colonoscopy_____ Full Physical _____
Chest X Ray _____ EKG_____

List any medications (including vitamins) **and** doses you are taking:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

List any allergies to any medications and your reaction to each:

_____ _____
_____ _____

List any medical conditions or illnesses

_____ _____
_____ _____

List all surgeries and dates of surgery

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____