Hunterdon Health

Patient Name (Last, First)	Birth Date (month/day/year)	Height	Weight

Medical History

1 Age at onset of first menstruation _____

2 Age at time of first full term pregnancy_____

3 Number of live births _____

4 Menopause ☐ Yes ☐ No ☐ Now ☐ Unknown

5 Are you taking hormones replacement therapy (HCT)?
☐ Current Use ☐ Never
☐ Stopped > 5 years ago ☐ Stopped < 5 years ago

6 Do you have a family history of breast, ovarian, or other gynecological cancer?
☐ Yes ☐ No ☐ Unknown

Family Member	Type of Cancer	Age at Onset	BRCA+
☐ Mother			☐
☐ Father			☐
☐ Maternal Grandmother			☐
☐ Paternal Grandmother			☐
☐ Maternal Aunt			☐
☐ Paternal Aunt			☐
☐ Sister			☐
☐ Brother			☐
☐ Daughter			☐
☐ Maternal cousin			☐
☐ Paternal cousin			☐
☐ _____			☐
☐ _____			☐

7 Since your last mammogram have you gained or lost more than 25 pounds?
☐ Yes ☐ No

8 Do you have breast implants?
☐ Yes ☐ No ☐ Removed

9 Have you had a surgical biopsy of your breast?
☐ Yes ☐ No
If Yes, which breast:
☐ Right ☐ Left ☐ Both
Year of most recent surgical biopsy _____

10 Have you had a needle biopsy of your breast?
☐ Yes ☐ No
If Yes, which breast:
☐ Right ☐ Left ☐ Both
Year of most recent needle biopsy _____

11 Have you ever had any other type of breast surgery?
☐ Yes ☐ No
If Yes, type of surgery:
☐ Reduction ☐ Other – describe _____
Year of surgery _____

12 Have you ever been diagnosed with:
☐ Hyperplasia ☐ Atypia ☐ Lobular carcinoma in situ

13 Have you had breast cancer? ☐ Yes ☐ No
Year diagnosed _____
☐ Lumpectomy ☐ Mastectomy
☐ Radiation ☐ Chemotherapy

14 Have you had ovarian cancer? ☐ Yes ☐ No

15 Have you tested positive for the BRCA gene mutation?
☐ No/Unknown ☐ Tested, normal
☐ BRCA1 ☐ BRCA2

16 Are you of Ashkenazi Jewish ancestry? ☐ Yes ☐ No

17 Do you currently have a breast complaint?
☐ Yes ☐ No
If Yes, what symptom: _____
Which breast: ☐ Right ☐ Left ☐ Both
Duration: _____

18 Are you pregnant or breast feeding? ☐ Yes ☐ No

19 Do you have a tattoo(s) above your waist?
☐ Yes ☐ No If Yes, where: _____

20 Have you had a recent vaccine injection in your arm?
☐ Yes ☐ No If Yes, when: _____
If Yes, ☐ Right arm ☐ Left arm

21 Have you had prior mammograms? ☐ Yes ☐ No
When was your last mammogram: _____
If not with us, where: _____