Hunterdon Health

Patient Name (Last, First)	Birth Date (Month/Day/Year)	Height	Weight

Medical History

1. Do you currently Have a breast complaint?
   ☐ Yes ☐ No
   If Yes, what symptom: ________________________
   Which Breast ☐ Right ☐ Left ☐ Both
   Duration: __________________________________

2. Have you had prior mammograms?
   ☐ Yes ☐ No
   When was your last mammogram: ______________
   If not with us, where: _________________________

3. Are you pregnant or breastfeeding?
   ☐ Yes ☐ No

4. Do you have a tattoo(s) above your waist?
   ☐ Yes ☐ No If Yes, where: ______________

5. Have you ever been diagnosed with
   ☐ Hyperplasia ☐ Atypia ☐ Lobular carcinoma in situ

6. Have you had a recent vaccine injection in your arm?
   ☐ Yes ☐ No If Yes, when: ______________

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

8. 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	__________	_____	☐
☐ ________________	__________	_____	☐
☐ ________________	__________	_____	☐

9. Do you have breast implants?
   ☐ Yes ☐ No

10. Have you had breast cancer?
    ☐ Yes ☐ No

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

12. Age at time of first full term pregnancy: ______________

13. Number of live births: ______________

14. Age at onset of first menstruation: ______________

15. Menopause ☐ Yes ☐ No ☐ Now ☐ Unknown
    Age: ______________

16. Have you had a needle biopsy of your breast?
    ☐ Yes ☐ No
    If Yes, which breast:
    ☐ Right ☐ Left ☐ Both

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

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

19. Are you of Ashkenazi Jewish ancestry?
    ☐ Yes ☐ No