

Advanced Breast Care of Georgia Health History Questionnaire

Name _____ Age _____ Date of Birth _____ Date _____
 Referring provider _____ GYN _____ PCP _____
 Last mammogram date and location (if not here) _____

Chief Complaint

Reason for visit	Yes	No	Right	Left	Additional Info/description (onset, duration, aggravating/alleviating factors)
Abnormal mammogram or Ultrasound					
Breast nodularity (general "lumpiness")					
Breast lump					
Breast tenderness/pain					
Nipple discharge					
Skin changes or lesion					
Lump in the axilla (under arm)					
Breast cancer (recent or past)					
Family history of breast cancer					
Annual screening mammogram					
Other:					

Current Medication- please list all medication (prescription, non prescription as well as hormones)

1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

Past Medical History- please list all current and past health problems and chronic disease

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|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

Drug Allergies- please list drug allergies/type of reaction _____

OB/GYN History

- Please indicate your age at the following: first menstrual period _____ or N/A; delivery of first child: _____ or N/A;
 Age of menopause _____ or N/A
- What is your current form of contraception? _____ or N/A
- Have you previously had counseling or testing for predisposition (genetic mutation) to breast or ovarian cancer? _____
 If so, what were the results/conclusion? _____

Surgical History- list name and date of *all* surgeries, also *include all breast procedures/biopsies*, date, provider & results

Date	Surgery