BOCA RATON REGIONAL HOSPITAL

CHRISTINE E. LYNN WOMEN'S HEALTH & WELLNESS INSTITUTE

THE CENTER FOR BREAST CARE

Last _____ First _____ MI _____ DOB _____

Home phone _____ Work phone _____ Work phone _____

Address _____ City _____ State _____ Zip _____

Email address _____ Referred by _____

Ethnicity _____

Do you currently smoke cigarettes? Yes _____ No _____ Have you ever smoked cigarettes? Yes _____ No _____

How many packs per day? _____ How many years did you smoke for? _____

Have you had a physical exam of the breast in the last 12 months by a physician or a practitioner? Yes _____ No _____

Family Risk Factors ☐ No Family History

	Relative	Age		Relative	Age
☐ History of breast cancer			☐ History of endometrial cancer		
☐ History of ovarian cancer			☐ History of high-risk breast lesion		
☐ History of pancreatic cancer			☐ History of colorectal cancer		

Patient's Personal Risk Factors ☐ No Personal History

	Age		Age
☐ History of breast cancer		☐ History of endometrial cancer	
☐ History of ovarian cancer		☐ History of high-risk breast lesion	
☐ History of pancreatic cancer		☐ History of colorectal cancer	

Breast Implants Yes _____ No _____

☐ Right Date _____ Saline / Silicone

☐ Left Date _____ Saline / Silicone

Gynecological History

	Age		Age		Age
First menstrual period		☐ Right ovary removed		☐ Menopause	
Number of live births		☐ Left ovary removed		☐ Hysterectomy	
First full-term pregnancy					

Hormone History *Check box if currently taking, and note duration* ☐ No Hormone History

	Years	Months		Years	Months
☐ Oral Contraceptives			☐ Tamoxifen		
☐ Estrogen			☐ Raloxifene		
☐ Progesterone			☐ Unspecified		

Breast Surgical and Treatment History Include date, type, and result _____

Current Complaints/Symptoms ☐ Yes ☐ No If YES, please describe:

Pain and/or soreness	☐ Right	☐ Left	
Lump (new or enlarging)	☐ Right	☐ Left	
Discharge from nipple	☐ Right	☐ Left	
Other	☐ Right	☐ Left	

Is this your first mammogram ? Yes _____ No _____ How long since your last mammogram ? Years _____ Mos _____

Where was your last mammography ? _____

The above information is correct. **Patient Signature** _____ Date _____