

Please answer all questions below.

1. General

of live births: _____
 Age Menstruation Began: _____
 Age First Full Term Pregnancy: _____
 Age at Menopause: _____
 Age at Hysterectomy: _____

2. Ovaries

Have you ever had ovaries removed? Yes No

3. Contraceptives

Currently (or ever) use Hormonal Contraceptives? Yes No

4. Estrogen

Currently (or ever) use estrogen? Yes No

5. Progesterone

Currently (or ever) use Progesterone? Yes No

6. Tamoxifen

Currently (or ever) use Tamoxifen? Yes No

7. Cyst Aspiration

Ever had a cyst aspiraton in either breast? Yes No

8. Needle Biopsy

Ever a needle biopsy in either breast? Yes No

9. Excisional Biopsy

Ever had an excisional biopsy in either breast? Yes No

10. Lumpectomy

Ever had an lumpectomy in either breast? Yes No

11. Reduction

Have you had a breast reduction? Yes No

12. Mastectomy

Ever had a mastectomy? Yes No

13. Radiation Therapy

Have you had radiation therapy in either breast? Yes No

14. Chemotherapy

Previous Chemotherapy (for any type of cancer)? Yes No

15. Implants

Do you have implants in either breast? Yes No

16. Implant Removal

Have you ever had an implant removed? Yes No

17. Do you practice breast self examination?

Yes No

Please indicate any current problems you are experiencing with your breasts and/or nipples

Lump in breast? If so, which breast(s)? _____

Nipple discharge? If so, which breast(s)? _____

Pain/soreness? If so, which breast(s)? _____

Have you had any previous mammograms? _____

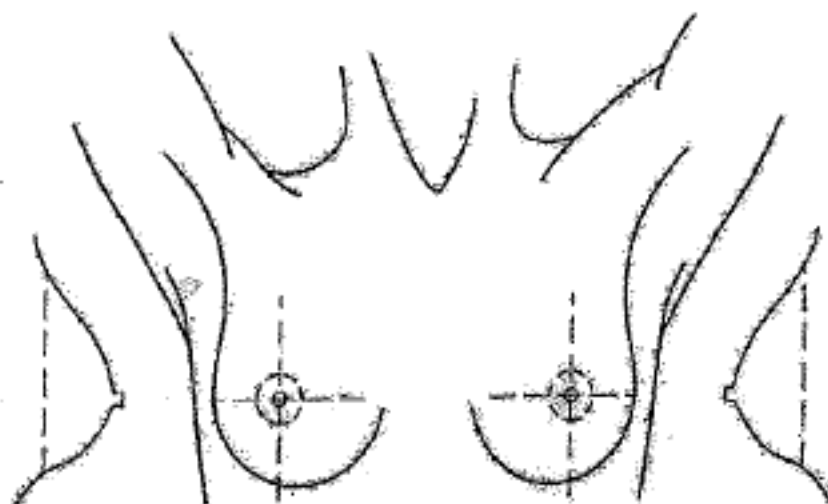
If so, when/where? _____

Any family history of breast cancer? _____

If so, who? _____ Age of diagnosis: _____

Other Notes: _____

Indicate the location(s) of any lump or pain/soreness



I attest that the answers I have provided to questions on this form are correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form.

Signature (Parent or Guardian)

Date Signed: _____