

**PATIENT DATA SHEET**

**BREASTS: FIRST OFFICE VISIT**

RACE: \_\_\_\_\_ AGE: \_\_\_\_\_

WHAT IS WRONG WITH YOUR BREAST? \_\_\_\_\_

AGE WHEN MENSTRUAL PERIODS FIRST STARTED: \_\_\_\_\_

AGE AT FIRST CHILD'S BIRTH: \_\_\_\_\_

HOW MANY PREGNANCIES? \_\_\_\_\_ HOW MANY BIRTHS? \_\_\_\_\_

BREAST – FEEDING? YES / NO

PLEASE LIST ANY FAMILY MEMBERS WHO HAVE HAD CANCER AND THEIR AGES:

BREAST: YES / NO \_\_\_\_\_

OVARIAN: YES / NO \_\_\_\_\_

PROSTATE: YES / NO \_\_\_\_\_

PLEASE LIST ANY PAST BREAST BIOPSIES YOU HAVE HAD (WHICH BREAST AND YEAR):

WERE ANY OF YOUR BREAST BIOPSIES ABNORMAL: \_\_\_\_\_ GAIL RISK  
FIVE YEAR \_\_\_\_\_  
LIFETIME \_\_\_\_\_

PLEASE LIST YOUR CAFFEINE INTAKE (Cups or glasses per average day): Coffee \_\_\_\_\_  
Soda \_\_\_\_\_ Tea \_\_\_\_\_ Chocolate \_\_\_\_\_

PLEASE LIST ALL YOUR CURRENT MEDICATIONS: (Include over-the-counter medications): \_\_\_\_\_

DO YOU HAVE NIPPLE DISCHARGE? \_\_\_\_\_

DO YOU DO SELF BREAST EXAMINATIONS? \_\_\_\_\_ HOW OFTEN? \_\_\_\_\_

DATE OF YOUR LAST MAMMOGRAM: \_\_\_\_\_

PLEASE LIST ANY ADDITIONAL CONCERNS YOU MAY HAVE: \_\_\_\_\_

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