

Marc Mandel, M.D., F.A.C.S.
Breast History

Name: _____

Date: _____

Reason for Visit: _____

(Male patients, skip Questions 1-4, 8, 10.)

1. Are you Pregnant? _____ Date of last period: _____

2. How old were you for your first period? _____

3. Have you been through menopause? _____ Age: _____

4. Are you on Hormone replacement therapy? _____ How long? _____

5. When was your last mammogram? _____

If yes, where? _____

6. Has anyone in your family ever had breast cancer? _____

If yes, relationship: _____

7. Has anyone in your family ever had ovarian cancer? _____

If yes, relationship: _____

8. How many children? _____ Age you had your first child: _____

9. Have you had BRCA Testing? _____ When? _____ Where? _____

10. What is your bra/cup size? _____

11. Please Check all that apply:

Right Breast

Left Breast

When

| | Right Breast | Left Breast | When |
|--------------------|---------------------|--------------------|-------------|
| Breast Cancer | | | |
| Breast Biopsy | | | |
| Breast Aspirations | | | |
| Lumpectomy | | | |
| Mastectomy | | | |
| Breast Implants | | | |
| Breast Reduction | | | |
| Breast lump | | | |
| Change in Color | | | |
| Breast Discharge | | | |
| Pain in Breast | | | |
| Radiation | | | |