Breast Care Center, A *branch* of Cedar Valley Medical Specialists, P.C.
1753 West Ridgeway Ave., Suite 104, Waterloo, IA 50701

#_____Name:_____DOB:_____

1. Are you here because of a breast lump? Yes No Can you feel it? Yes No
2. Are you here because of an abnormal mammogram? Yes No
3. How long have you had this problem or known about this problem? _____
4. Do you have any children? Yes No
5. What age were you at your first live birth? _____
6. Did you breastfeed? Yes No
7. Age your menstrual periods started _____ Date of your last menstrual period_____
8. Age at which you stopped having your menstrual cycle _____
9. Do you currently take: Birth Control Pills? Yes No Hormone replacement? Yes No
10. Did you ever use hormone replacement? Yes No If yes – for how long? _____
11. Have your breasts been tender? Yes No
12. Any breast or nipple discharge? Yes No Is the discharge bloody? Yes No
    Which breast? Right Left Is the drainage spontaneous? Yes No
13. Have you had any lumps in your breast before? Yes No If yes, which breast? Right Left
14. Have you had any breast biopsies done? Yes No
    If yes, Which breast? Right Left How many?_____ Findings:_____
15. Do you do monthly self breast examinations? Yes No Sometimes Rarely
    Would you like information on how to do breast self exam today at your visit? Yes No
16. Has anyone in your family had breast problems? Yes No
    If yes, what kind of problem(s)?_____
17. When and where did you have your last mammogram?_____

Personal or Family History of <u>Breast or Ovarian</u> Cancer:

Family includes *parents, children, siblings, grandparents, aunts, uncles & cousins*

Please mark below if there is a *personal or family history* of breast or ovarian cancer.

Please indicate their relation to you and on which side of your family, also their *age when diagnosed*.

EXAMPLE:	**Self :**	**Age @ diagnosis**	**Mother's side:**	**Age @ diagnosis**	**Father's side:**	**Age @ diagnosis**	**Children/Siblings:**	**Age @ diagnosis**
Breast Cancer	**X**	**42**	**grandmother**	**50**	**aunt**	**74**	**sister**	**57**

	Self :	**Age @ diagnosis**	**Mother's side:**	**Age @ diagnosis**	**Father's side:**	**Age @ diagnosis**	**Children/Siblings:**	**Age @ diagnosis**
Breast Cancer								
Ovarian Cancer								
Breast Cancer in both breasts OR multiple primary breast cancers.								
Male Breast Ca								

18. Are you of Ashkenazi Jewish decent? Yes No

Gail Score
_____5 yr _____Lifetime