SURGICAL ASSOCIATES OF FREDERICKSBURG

4548 Empire Court Fredericksburg, VA 22408

Breast Cancer History And Risk Assessment

Patient name_____ Date of Birth _____ Today's Date_____

Date of Last: Mammogram _____ Ultrasound _____

Age of first menstrual period: _____ Are you menopausal?_____

Have you taken hormone replacement therapy? Yes/No How long?_____

LMP: _____ # Pregnancies?:_____ # Births?:_____

Age of first live birth: _____ Did you breastfeed? Yes/No Any problems? _____

Previous breast biopsy? Yes/No Date _____ Result of biopsy_____

Previous breast surgery? Yes/No If yes, when?_____ Type of surgery_____

Any recent changes and/or concerns:

	Right	Left	Cyclic
□ Lump	□	□	□
□ Nipple Discharge	□	□	□
□ Nipple /skin retraction	□	□	□
□ Erythema/swelling	□	□	□
□ Rash/scaling/itching	□	□	□
□ Breast pain	□	□	□
□ Other: _____	□	□	□

□ None

FAMILY HISTORY (both mother/father history is relevant. Include parents, sisters, aunts, cousins)

	Relation	Age at Diagnosis
Breast Cancer	_____	_____
	_____	_____
	_____	_____
Ovarian Cancer	_____	_____
Other	_____	_____
	_____	_____

Any other breast health concerns?