

Alamo City Surgeons | Breast Screening Assessment

Date: _____ Name: _____ Date of birth: _____

Referring doctor: _____ Home phone: _____

Cell phone: _____ Work phone: _____

Medication allergies: _____ Current medications: _____

- | | | | |
|--|-------|-------|--------------------------|
| 1. Present Condition | Right | Left | |
| No problem noticed by me | _____ | _____ | |
| Breast lump/mass | _____ | _____ | |
| Breast pain/tenderness | _____ | _____ | |
| Abnormal mammogram | _____ | _____ | |
| Nipple discharge | _____ | _____ | Color of discharge _____ |
| Do you take female hormones or birth control pills at present? | _____ | _____ | Which? _____ |

2. Menstrual History
Age menstruation began _____ Age menstruation stopped (if applicable) _____
Age at first pregnancy _____ Total pregnancies _____ Total births _____
Have you had your uterus and/or ovaries removed? _____ If so, why? _____

3. Family History
Breast cancer in blood relatives? No _____ Yes _____ Relationship _____
Age at diagnosis _____

- | | | | |
|---|-------|-------|-----------------------|
| 4. Past History | Right | Left | |
| Mastitis (breast infection) | _____ | _____ | |
| Cyst aspiration (fluid sample) | _____ | _____ | |
| Breast biopsy (tissue sample) | _____ | _____ | |
| Breast cancer | _____ | _____ | |
| Mammoplasty/augmentation/implants | _____ | _____ | |
| Previous mammograms: Yes _____ Where? _____ | | | Year _____ None _____ |

5. Other medical problems (Such as heart, lung, liver, kidney disease; high blood pressure, diabetes, etc.) _____

6. Surgical history _____