Main Line HealthCare
Physician Network

SURGICAL ASSOCIATES
Breast Disease History Form

Name: _____ Date: _____

Do you currently have a breast lump that you can feel? □ Yes □ No
If yes, when was it first noticed? _____
Was it noted by another physician on examination? □ Yes □ No
If so, please list this physician's name: _____
Has the lump changed in size? □ Yes □ No
Does its size vary with your menstrual cycle? □ Yes □ No

Do you have nipple discharge? □ Yes □ No
If yes, is this painful? □ Yes □ No

Have you had a recent:
Mammogram? □ Yes □ No; Date of study? _____, where? _____
Ultrasound? □ Yes □ No; Date of study? _____, where? _____

Have you ever had a breast aspiration or biopsy? □ Yes □ No
If yes, please indicate **when this occurred, which breast was tested, the facility, and the result:**
_____
_____

Do you take hormones or birth control pills? □ Yes □ No
If yes, for how long? _____

Caffeine intake: (approx. # of servings per day – coffee, tea, chocolate, cola, nuts) _____

Previous History:

Age of menstrual onset? _____ Is your cycle regular? □ Yes □ No
Last menstrual period? _____
Have you gone through menopause? □ Yes □ No Age of onset? _____

Pregnancies: How many? _____ Any abortions or miscarriages? _____
Number of deliveries (vaginal or cesarean)? _____
Age of first pregnancy? _____ Did you breast feed? _____

Do you have a personal history of breast cancer? □ Yes □ No
Any other type of cancer? □ Yes □ No _____
Do you have a **family history of breast cancer**? □ Yes □ No
If yes, please indicate the relationship to you and age of onset (if known):
_____
Do you have a **family history of any other type of cancer**? □ Yes □ No
If yes, please indicate the relationship to you and age of onset (if known):
_____

_____ _____
Patient (or Patient Representative) Signature Physician Signature