NORTH FLORIDA surgeons Volusia Division

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Breast Information Sheet

Account # _____ Date: _____

Name: _____ DOB: _____ Age: _____

BREASTS: Pleas check "no" or "yes and if "yes", circle which specific side.

1. Have you felt any of the following?
   - Cysts: □ No □ Yes - Right / Left
   - Thickening: □ No □ Yes - Right / Left
   - Soreness or discomfort: □ No □ Yes - Right / Left
   - Nipple change (inverted): □ No □ Yes - Right / Left
   - Nipple discharge: □ No □ Yes - Right / Left
   - Change in color/size: □ No □ Yes - Right / Left
2. Have you had a previous:
   - Lumps: □ No □ Yes - Right / Left
   - Cyst: □ No □ Yes - Right / Left
   - Mastectomy: □ No □ Yes - Right / Left
   - Breast Biopsy: □ No □ Yes - Right / Left
   - Cyst aspiration: □ No □ Yes - Right / Left
3. Has anyone in your family had breast cancer?
   □ No □ Yes - Relation: _____
4. Number of pregnancies
   - Including miscarriages: _____
   - Age at first pregnancy: _____
5. Did you breastfeed at any time? □ No □ Yes
6. Are you taking birth control pills? □ No □ Yes
7. Are you taking any other hormones? □ No □ Yes
8. Have you had a hysterectomy? □ No □ Yes - When: _____
9. Did you go through menopause? □ No □ Yes - When: _____
10. Date of last menstrual period: _____
11. Age when you first menstruated: _____
12. Have you had a previous mammogram? Where: _____
    When: _____