

Breast Health History Form updated 4/10/2018

Patient's Name: _____ Date: _____ Bra Size _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone: _____ Date of Birth: _____ Age: _____

Email Address: _____ Last Menstrual Cycle Start Date: _____

How did you find out about our services? Example: Google, Doctor, friend, etc. _____

Why did you choose OC Breast Wellness? _____

Do you have any family history of breast cancer? Self Mother Sister Daughter None
Maternal – Grandmother Aunt Cousin Paternal – Grandmother Aunt Cousin

Do you have any diagnosed breast conditions? None Fibrocystic Cystic Other _____

When was the date of your last mammogram? _____

Was it: Normal Abnormal Suspicious Something is being watched – R L Breast

When was the date of your last breast ultrasound? _____ Were both breasts imaged? Y N

Was it: Normal Abnormal Suspicious Something is being watched – R L Breast

Date of last physical breast exam by a doctor _____ Normal Lump found – R L Breast

Any breast biopsies? When and what type (i.e. needle, excisional)? _____ R L Breast

What was found on the biopsy? Cancer Other _____ R L Breast

Any breast surgeries? When and what was done? _____ R L Breast

Have you had a mastectomy? If yes, when? _____ R L Breast

Any breast reconstruction? When and what was done? _____ R L Breast

If you have had any radiation treatment, when was it last performed? _____ R L Breast

Are you currently pregnant? Y N Current cycle day (number of days since first day of period) _____

If you've used birth control pills, at what age did you start? _____ How many years have you taken them? _____

Are you currently taking them? Y N

How many childbirths? _____ Did you breast feed? Y N

If you have passed menopause, at what age did it begin? _____

If you are taking hormone replacement, at what age did you start? _____ How many years taken? _____

Are you currently taking hormones? Y N (check only if by prescription): Estrogen Progesterone

Are you currently using herbs or supplements to stimulate or simulate estrogen? Y N

Are you currently using any other medications? If yes, what? (i.e. Tamoxifen) _____

Are you currently using a progesterone cream (applied to: Breasts only Rotating body areas) Y N

Have you had your ovaries removed? If yes, at what age? _____

Have you had your vitamin D levels checked? If yes, at what were the results? _____

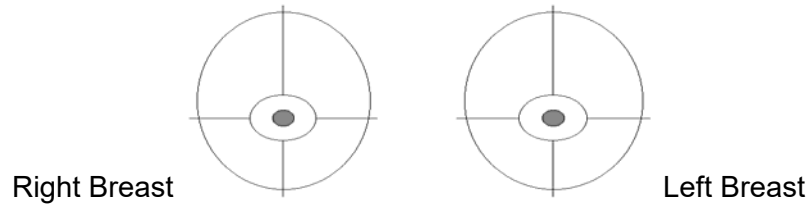
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Continued

Are you experiencing any of the following with your breasts: None

- A Lump (date found _____; by Self Doctor. Is it Hard Soft Mobile Tender)
 Pain: Dull Sharp Burning Stinging Tenderness The pain or tenderness changes with my cycle
 Thickening Skin changes (Color Texture Over the lump)
 R L Nipple discharge (Bloody Milky Clear Through 1 duct Through multiple ducts)
 R L Nipple retraction R L Nipple Changes (Color Texture)
 Other _____

Place an [O] on the diagram in the exact area of the lump, finding on your mammogram, or area being watched, and an [X] in the area of pain, tenderness, thickening, or skin changes.



If you would like a copy of your report sent to your doctor(s), please complete information below

 Physician's Name

 Physician's Phone Number

 Physician's Address

 Physician's City, State, Zip

 Specialist's Name

 Specialist's Phone Number

 Specialist's Address

 Specialist's City, State, Zip

Breast thermography is not a diagnostic procedure and should not be used as the sole means to breast abnormalities. It is only a screening procedure to aid in the detection of breast cancer and its precursors. Both false-negative and false-positive results have been experienced. _____

Initials

SureTouch is currently cleared by the FDA for documenting palpable breast lesions. The SureTouch system should not be used as a substitute of MRI, ultrasound, or breast biopsy. _____

initials