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MD FRCSEd FRACS
Breast & General Surgeon
Provider Number: 4544745X

TOOWOOMBA CUTTING EDGE SURGERY

BREAST HEALTH FORM

1. Reason for your visit today:

2- Who referred you to us?

_____

3. Who is your GP?

_____

BREAST HISTORY

1. Please indicate any Breast Symptoms you are currently experiencing:

Mass or Lump: ☐ No ☐ Yes
Skin Changes: ☐ No ☐ Yes
Nipple Discharge: ☐ No ☐ Yes
Other:

Breast Pain: ☐ No ☐ Yes Duration of symptoms: _____

2. When was your last mammogram? Date: _____ Facility:

Have you had a Breast ultrasound? Date: _____ Facility:

Have you had an Breast MRI? Date: _____ Facility:

3. Have you ever had a *previous breast biopsy*? ☐ No ☐ Yes Side: ☐ Left ☐ Right

4. Do you have a history of *prior breast cancer*? ☐ No ☐ Yes Side: ☐ Left ☐ Right
If yes, year diagnosed: _____

How was your prior breast cancer treated? ☐ Lumpectomy ☐ Mastectomy

Did you have lymph node(s) removed? ☐ No ☐ Yes ☐ Sentinel nodes ☐ All lymph nodes
Did you receive radiation therapy? ☐ No ☐ Yes – If yes, when?
Did you receive chemotherapy? ☐ No ☐ Yes
Did you receive hormone-blocking/endocrine therapy? ☐ No ☐ Yes

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FAMILY HISTORY

1. Are you of Ashkenazi Jewish (Eastern European Jewish) Descent: ☐ No ☐ Yes
2. Do you have a **family history of breast cancer?** ☐ No ☐ Yes ☐ Unknown
3. Do you have a **family history of ovarian cancer**? ☐ No ☐ Yes ☐ Unknown
4. Do you have a **family history of other cancers**? ☐ No ☐ Yes ☐ Unknown

If yes to any of the above, please list family members below.

Relative	Maternal/Paternal	Cancer Type	Age at cancer diagnosis	Current Age, if living	Age at death, if deceased

GYNECOLOGIC HISTORY

1. Age at onset of first period? _____ Last menstrual period? _____

2. Have you experienced menopause? ☐ No ☐ Yes Age at menopause:

3. Have you had a hysterectomy? ☐ No ☐ Yes Removal of ovaries? ☐ No ☐ Yes

4. How many pregnancies have you had? _____ How many live births?

5. How old were you when your first child was born? _____ Did you Breastfeed? ☐ No ☐ Yes

6. Have you ever had fertility treatments? ☐ No ☐ Yes

7. Have you ever used hormone-based birth control? ☐ No ☐ Yes
Age started: _____ Age stopped: _____

8. If post-menopausal, have you ever used hormone replacement therapy? ☐ No ☐ Yes
Age started: _____ Age stopped: _____

PERSONAL/SOCIAL HISTORY

Ethnicity: ☐ Caucasian ☐ Asian ☐ Aboriginal ☐ Other _____

Marital Status: ☐ Single ☐ Married ☐ Domestic Partnership ☐ Divorced ☐ Widowed

Do you have children? ☐ No ☐ Yes

If yes, what are their ages?

_____

Are you currently employed? ☐ No ☐ Yes

If yes, what is your occupation? _____

Are you currently smoking? ☐ No ☐ Yes

If yes, how much do you smoke? _____packs/day

If you have quit smoking, how long ago did you quit? _____

How many years did you smoke? _____ How much? _____ pack/day

Do you drink alcohol? ☐ No ☐ Yes – Number of drinks per day: _____ per week:

Describe your daily activity level: (*Mark only ONE that best describes you now):*

☐ I am fully active and am able to carry on all usual activities without restriction

☐ I am restricted in physically strenuous activity, but can walk and am able to carry on light housework

☐ I can walk and take care of myself, but am unable to carry out work activities

☐ I need help taking care of myself and I spend more than half of the day in bed or a chair

☐ I cannot take care of myself at all and spend most of the day in bed

REVIEW OF SYSTEMS:

Past Medical History:

Chest & Lung	
Heart	
Liver	
Kidney	
Central Nervous System	
High BP	
Diabetes	
Thyroid	
Gastrointestinal	
Others	

Previous Surgeries:

	Date	***Operation***
1		
2		
3		
4		
5		
6		
7		

Smoking: Current YES/NO	***Ex-Smoker: How long:***	***Quit Date:***
Alcohol Intake: YES/NO	***Amount:***	