

St. John Health System High Risk Breast Clinic

Name: _____ Age: _____

GYN History

Age of First Period: _____ Last Menstrual Cycle: _____

Age of First Birth: _____ # of Pregnancies: _____ # of Children: _____

Did you Breast Feed : Y/N How Long Did you Breast Feed: _____

Infertility Medications: Y/N How many treatments: _____

Oral Contraceptives: Y/N How long: _____

Hormone Replacement Therapy: Y/N How long: _____

Previous Breast Surgery: Y/N Year: _____ Type of Surgery: _____

Previous Breast Biopsy: Y/N Year: _____ Atypical Cells: Y/N _____

Breast Reduction: Y/N Year: _____

Breast Implants: Y/N Year: _____

Nipple Discharge: Y/N Bloody: Y/N

Breast Skin Changes: Y/N

Family History

Ethnicity: _____ Are you of Ashkenazi Jewish Descent: Y/N

Family History: Y/N	Relation To You	Ages of Diagnosis
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Breast Cancer	_____	_____
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Ovarian Cancer	_____	_____
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Prostate Cancer	_____	_____
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Melanoma	_____	_____
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Uterine Cancer	_____	_____
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Pancreatic Cancer	_____	_____
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Other Cancer	_____	_____
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Does anyone in the family have a known genetic mutation? Y/N If yes, who? _____