Fall Precaution Y N

Women & Children
HUNTSVILLE HOSPITAL

BCMAM

Patient Sticker

Huntsville & Madison Hospital Breast Centers

PATIENT INFORMATION

Last Name	First Name/Middle Initial	DOB	Age	Race
		/ /		

Year and location of your last mammogram_____

Year of your last breast exam performed by a healthcare professional_____

CURRENT SYMPTOMS

	Which breast?	Duration?
Lump:	L / R	_____
Nipple inversion:	L / R	_____
Discharge:	L / R	_____
Color of discharge:		_____
Skin retraction:	L / R	_____
Tenderness :	L / R	_____

Other symptoms: _____

_____

HORMONE HISTORY

Date of your last menstrual period: _____

Have you ever taken hormones?: ___no __yes

If yes, list type (birth control pills, hormone replacement, etc) and dates of use:

_____

_____

_____

Breast fed in the last six months? ____no ___yes

Currently breast feeding? ____no ___yes

Has your weight changed by more than 15 lbs since your last mammogram? ____no ___yes

If yes, please specify:_____

BREAST SURGICAL & BIOPSY HISTORY

Breast reduction: ___no ___yes if yes, year _____

Implants: ___no ___yes if yes, year _____

Please list any previous benign breast surgeries or biopsies, including which breast and the approximate year:

_____

_____

_____

BREAST CANCER HISTORY

Have you ever had breast cancer? ____no ____yes

If yes, please answer the following:

Which breast? ____ right _____ left

Year of diagnosis_____

Type of surgery: ___lumpectomy __mastectomy

Did you have chemotherapy?: ____no ____yes

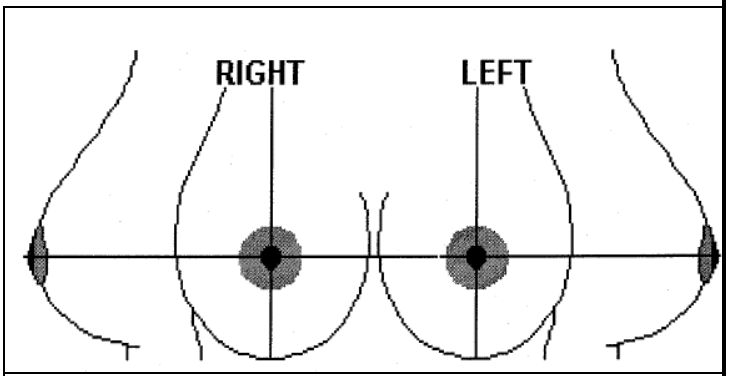
Did you have radiation?: ____no ____yes

Name of surgeon: _____

Name of medical oncologist: _____

Name of radiation oncologist: _____

FOR TECHNOLOGIST USE ONLY



TECHNOLOGIST COMMENTS

_____

TECHNOLOGIST SIGNATURE, DATE & TIME

Huntsville and Madison Hospital Breast Centers

Personal and Family History Questionnaire

Patient Label

Date Completed: _____

What was your age at the time of your first menstrual period? _____

Have you been pregnant before? ____ yes ____no If yes, please provide your age at delivery of your first child: ____

Instructions: Please circle Y to those that apply to **YOU** and/or **YOUR FAMILY** (on your mother or father's side.) In the spaces provided, please list the relationship and the age of diagnosis. Please specify **"maternal"** and **"paternal"** when listing affected relatives.

		Breast Cancer Risk Assessment	Relationship(s) to you	Age(s) at Diagnosis
Y	**N**	Have YOU had breast cancer?		
Y	**N**	Do you have a family history of breast cancer in your **mother, daughter, and/or sister(s)?**		
Y	**N**	Has your **father or brother** had breast cancer?		
Y	**N**	Have YOU been tested for BRCA or other genetic mutations? If so please list the mutation and the result (positive or negative)		
Y	**N**	To your knowledge, have any blood relatives been tested for BRCA or other genetic mutations? If so please list the mutation and the result (positive or negative)		
Y	**N**	Did YOU have radiation treatments to the chest between the ages of 10 and 30 for treatment of **cancer**, such as lymphoma?		
Y	**N**	Do YOU have a history of atypical lobular hyperplasia, atypical ductal hyperplasia, or lobular carcinoma in situ?		

		Additional Information	Relationship(s) to you	Age(s) at Diagnosis
Y	**N**	Do you have a family history of breast cancer in other relatives such as grandmothers or aunts (please specify paternal or maternal)?		

Patient Signature **Date** **Technologist Signature** **Date**