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FEMALE HEALTH HISTORY

NAME _____

DATE _____

REASON FOR TODAY'S VISIT _____

MENSTRUAL HISTORY: Age of start _____ Periods usually regular? _____

Date of start of last cycle _____ Duration of period _____

Number of pregnancies _____ Number of term births _____

Age at first full term pregnancy _____ Have you breast-fed? _____

Menopause? Y N Date of start _____

Do you do monthly self-breast exams? Y N

PREVIOUS GYNECOLOGICAL SURGERY:

Type _____ Date(s) _____ Doctor _____

Type _____ Date(s) _____ Doctor _____

PREVIOUS BREAST SURGERY AND TREATMENT:

Biopsy? R L (circle one) Date _____ Diagnosis _____

Biopsy? R L (circle one) Date _____ Diagnosis _____

Mastectomy R L (circle one) Date _____

FAMILY HISTORY OF BREAST CANCER:

Relationship _____ Age diagnosed _____

Treatment & Result _____

Relationship _____ Age diagnosed _____

Treatment & Result _____

(over)

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CURRENT MEDICATIONS:

Birth control _____

Hormone therapy _____

Blood pressure _____

Thyroid _____

Others _____

Caffeine intake per day _____ Do you use soy products? Y N (circle one)

Vitamin E? Y N (circle one) Homeopathic medications? Y N (circle one)

Additional comments or concerns: _____

Note to our patients:

It is important for you to realize that breast tissue changes continually. At the time of your examination, it may not be felt that an abnormality requires surgery. This may change before your next recommended routine exam. If you notice abnormalities, please contact our office to speak with a medical assistant and possibly make an appointment with the doctor. You are the most qualified person to find irregularities in your body. Please do not hesitate to bring them to the doctor's attention. Your input in these matters is extremely important and greatly appreciated.

Signature of the patient: _____ Date: _____

(over)