

GAINESVILLE SURGICAL ASSOCIATES  
Breast Information Sheet

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

What is your concern today? \_\_\_\_\_

Age at 1<sup>st</sup> menstrual period \_\_\_\_\_ Last period \_\_\_\_\_ Age at menopause \_\_\_\_\_

How many pregnancies have you had? \_\_\_\_\_ Your age at first pregnancy? \_\_\_\_\_

Prior breast biopsies? Y N Where? \_\_\_\_\_ Result? \_\_\_\_\_

Has anyone in your close family had breast cancer? Y N Who? \_\_\_\_\_

What was their age when first diagnosed? \_\_\_\_\_

Date of last mammogram: \_\_\_\_\_ Where? \_\_\_\_\_

Do you take any hormones of birth control pills (including natural or alternative medicines)? If yes, please list.  
\_\_\_\_\_

Do you perform a monthly breast self-exam? Y N

Do you have any of the following:

Breast Pain? Y N

Breast lumps? Y N

Nipple Discharge? Y N

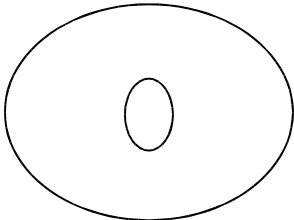
Any problems with your ovaries or uterus? Y N If yes, what? \_\_\_\_\_

Have you had a hysterectomy? Y N Were your ovaries removed? Y N  
If Yes, when? \_\_\_\_\_

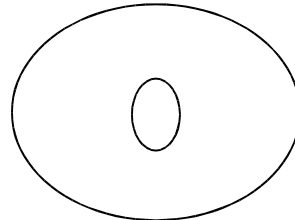
Anything else I should know? \_\_\_\_\_

Please indicate by marking an X where the problem is.

Right Breast



Left Breast



Reviewed by: \_\_\_\_\_  
(Physician's Initials)