

## Breast Health History – Initial Visit

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Cell: \_\_\_\_\_ Home: \_\_\_\_\_ E-mail: \_\_\_\_\_

Occupation: \_\_\_\_\_ Marital Status: S M D W SEP # of Children: \_\_\_\_\_

Y  N Do you have a family history of breast cancer?  
 Self  Mother  Maternal Grandmother  Sister  Daughter  None

Y  N Do you have any diagnosed breast conditions?  
 None  Fibrocystic  Cystic  Other \_\_\_\_\_

Y  N Have you previously had a thermogram? Date of most recent \_\_\_\_\_  
Was it:  Normal  Abnormal  Suspicious  Being watched  R  L Breast

Y  N Have you had a mammogram? Date of most recent \_\_\_\_\_  
Was it:  Normal  Abnormal  Suspicious  Being watched  R  L Breast

Y  N Have you had a breast ultrasound? Date of most recent \_\_\_\_\_  
Was it:  Normal  Abnormal  Suspicious  Being watched  R  L Breast

Y  N Have you had a breast exam by a doctor? Date of most recent \_\_\_\_\_  
Was it:  Normal  Lump Found  R  L Breast

Y  N Any breast biopsies? When and what type (i.e. needle, core)? \_\_\_\_\_  R  L Breast

Y  N Any breast surgeries? When and what was done? \_\_\_\_\_  R  L Breast

Y  N Have you had a mastectomy? When? \_\_\_\_\_  R  L Breast

Y  N Have you had radiation? When was it last performed? \_\_\_\_\_  R  L Breast

Y  N Have your had your ovaries removed? At what age? \_\_\_\_\_

Y  N Do you have children. At what age was your first full term pregnancy? \_\_\_\_\_

Y  N Did you nurse for at least three months? How long \_\_\_\_\_

Y  N Are you currently nursing?

- Y  N Are you currently pregnant?
- Y  N Are you currently taking birth control pills?  
At what age did you start? \_\_\_\_\_ for how many years? \_\_\_\_\_
- Y  N Are you in menopause? At what age did it begin? \_\_\_\_\_
- Y  N Have you ever taken synthetic hormone replacement (ex. Premarin, Provera)?  
How many years taken? \_\_\_\_\_
- Y  N Are you currently using natural progesterone cream?  
Applied to  Breasts only  Rotating body areas
- Y  N Are you currently using herbals, homeopathic medicines, or supplements to stimulate or simulate estrogen? Explain \_\_\_\_\_
- Y  N Do you feel that you are overweight? How many pounds overweight? \_\_\_\_\_

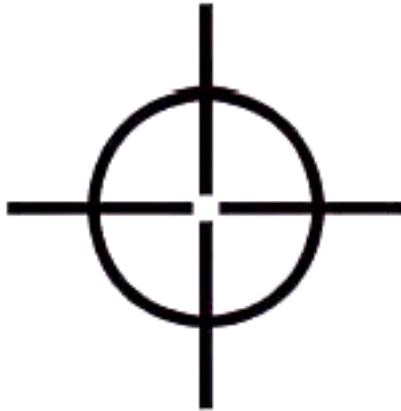
### Are you experiencing any of the following with your breasts?

- Y  N A lump. Date found: \_\_\_\_\_ by  Self  Doctor  R  L Breast  
It is:  Hard  Soft  Mobile  Tender
- Y  N Pain  R  L Breast  
It is  Dull  Sharp  Burning  Stinging  Tender  Changes with my cycle
- Y  N Thickening  R  L Breast
- Y  N Skin changes (  Color  Texture  Over the lump)
- Y  N Nipple discharge  R  L Breast  
It is  Bloody  Milky  Through one duct  through multiple ducts
- Y  N Nipple retraction  R  L Breast
- Y  N Nipple changes  R  L Breast  
Change in:  Color  Texture
- Y  N Other \_\_\_\_\_

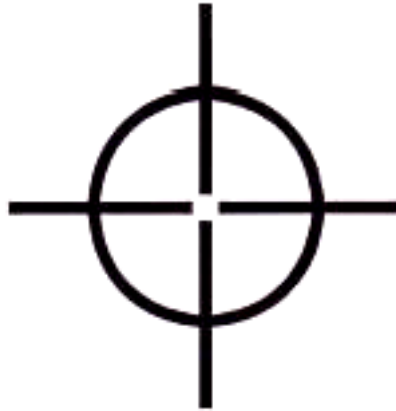
Please note any other concerns/issues you may have: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Place an [O] on the diagram in the exact area of the lump, findings on your mammogram, or area being watched, and a [X] in the area of pain, tenderness, thickening, or skin changes.



Right Breast



Left Breast

## General Health Information

Y  N Do you have any medical complaints or conditions? Please explain \_\_\_\_\_

\_\_\_\_\_

Y  N Are you currently taking any medications? Please list \_\_\_\_\_

\_\_\_\_\_

**Please circle all of the following conditions which you have had:**

- |             |             |                  |                             |                 |                |
|-------------|-------------|------------------|-----------------------------|-----------------|----------------|
| Abscesses   | Depression  | Heart Disease    | Mononucleosis               | Rheumatic Fever | Syphilis       |
| Addiction   | Diabetes    | Hepatitis        | Mumps                       | Rubella         | Tonsillitis    |
| Allergies   | Emphysema   | Herpes Genitalia | Parasites                   | Scarlet Fever   | Tuberculosis   |
| Amnesia     | Epilepsy    | Influenza        | Pelvic Inflammatory Disease | Sexual Abuse    | Typhoid Fever  |
| Arthritis   | Gall Stones | Kidney Disease   | Disease                     | Skin Disease    | Venereal Warts |
| Asthma      | Goiter      | Leukemia         | Peritonitis                 | Strep Throat    | Warts          |
| Cancer      | Gonorrhea   | Malaria          | Pleurisy                    | Sinusitis       | Whooping Cough |
| Chicken Pox | Gout        | Measles          | Pneumonia                   | Sunstroke       | Worms          |
| Cold Sores  | Hay Fever   | Miscarriage      | Prostatitis                 | Stroke          | Yellow Fever   |
| Other _____ |             |                  |                             |                 |                |

# Healthworks

NUTRITION CENTRE

Y  N Are there any of the preceding conditions after which you have never been totally well again, or which have been more severe than usual? Explain? \_\_\_\_\_

\_\_\_\_\_

Y  N Have you had any operations? Which \_\_\_\_\_

Y  N Have you lost any weight recently? How many pounds? \_\_\_\_\_

Y  N Do you exercise? How often? \_\_\_\_\_

Y  N Have you had any major injuries? Explain \_\_\_\_\_

Y  N Are you taking any of the following substances? How much?

Tobacco: \_\_\_\_\_ Alcohol: \_\_\_\_\_

Coffee: \_\_\_\_\_ "Recreational Drugs" \_\_\_\_\_

Y  N Have any of the following ailments affected your relatives?

- |            |            |            |               |                |              |
|------------|------------|------------|---------------|----------------|--------------|
| Alcoholism | Asthma     | Diabetes   | Gout          | Mental Illness | Skin Disease |
| Allergies  | Cancer     | Epilepsy   | Hay Fever     | Paralysis      | Syphilis     |
| Arthritis  | Depression | Gonorrhoea | Heart Disease | Pneumonia      | Tuberculosis |

<b>FAMILY HISTORY</b>	<b>Age, if Alive</b>	<b>Age at Death</b>	<b>AILMENTS</b>
Mother:			
Father:			
Brothers:			
Sisters:			
Children:			
Maternal Grandmother:			
Maternal Grandfather:			
Paternal Grandmother:			
Paternal Grandfather:			

Signature: \_\_\_\_\_ Date: \_\_\_\_\_