

Breast Health History Form

11770 Warner Ave #111
Fountain Valley, CA 92708
714-363-5595

Patient's Name: _____ Date: _____ Bra Size _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Date of Birth: _____ Age: _____ Sex: _____

Email Address: _____ Menstrual Cycle Start Date: _____

How did you find out about our services? Example: Google, Doctor, friend, etc. _____

Why did you choose OC Breast Wellness? _____

Do you have any family history of breast cancer? Self Mother Sister Daughter None
Maternal – Grandmother Aunt Cousin *Paternal* – Grandmother Aunt Cousin

Do you have any diagnosed breast conditions? None Fibrocystic Cystic Other _____

When was the date of your last mammogram? _____

Was it: Normal Abnormal Suspicious Something is being watched – R L Breast

When was the date of your last breast ultrasound? _____ Were both breasts imaged? Y N

Was it: Normal Abnormal Suspicious Something is being watched – R L Breast

Date of last physical breast exam by a doctor _____ Normal Lump found – R L Breast

Any breast biopsies? When and what type (i.e. needle, excisional)? _____ R L Breast

What was found on the biopsy? Cancer Other _____ R L Breast

Any breast surgeries? When and what was done? _____ R L Breast

Have you had a mastectomy? If yes, when? _____ R L Breast

Any breast reconstruction? When and what was done? _____ R L Breast

If you have had any radiation treatment, when was it last performed? _____ R L Breast

Are you currently pregnant? Y N Current cycle day (number of days since first day of period) _____

If you've used birth control pills, at what age did you start? _____ How many years have you taken them? _____

Are you currently taking them? Y N

If you have passed menopause, at what age did it begin? _____

If you are taking hormone replacement, at what age did you start? _____ How many years taken? _____

Are you currently taking hormones? Y N (check only if by prescription): Estrogen Progesterone

Are you currently using herbs or supplements to stimulate or simulate estrogen? Y N

Are you currently using any other medications? If yes, what? (i.e. Tamoxifen) _____

Are you currently using a progesterone cream (applied to: Breasts only Rotating body areas) Y N

Have you had your ovaries removed? If yes, at what age? _____

Have you had your vitamin D levels checked? If yes, at what were the results? _____

Breast Thermography is not a diagnostic procedure and should not be used as the sole means to breast abnormalities. It is only a screening procedure to aid in the detection of breast cancer and its precursors. Both false-negative and false-positive results have been experienced.

SureTouch is currently cleared by the FDA for documenting palpable breast lesions. The SureTouch system should not be used as a substitute for clinical breast examination, mammography, ultrasound, or breast biopsy.

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Continued

Are you experiencing any of the following with your breasts: None

A Lump (date found _____; by Self Doctor. Is it Hard Soft Mobile Tender)

Pain: Dull Sharp Burning Stinging Tenderness The pain or tenderness changes with my cycle

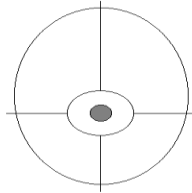
Thickening Skin changes (Color Texture Over the lump)

R L Nipple discharge (Bloody Milky Clear Through 1 duct Through multiple ducts)

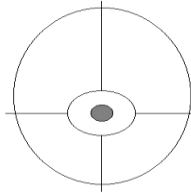
R L Nipple retraction R L Nipple Changes (Color Texture)

Other _____

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



Right Breast



Left Breast

If you would like a copy of your report sent to your doctor(s), please complete information below

Physician's Name

Physician's Phone Number

Physician's Address

Physician's City, State, Zip

Specialist's Name

Specialist's Phone Number

Specialist's Address

Specialist's City, State, Zip

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