

HISTORY FORM

Date: _____

Name & Surname: _____

Date of birth: _____ Age: _____

Breast Complaints: _____

1. Have you had a mammogram before?			
2. When and where?			
3. Are You Pregnant?			
3.1 When was your last menstrual period?			
4. Are you going through, or have you been through Menopause?			
5. No of pregnancies: _____ No of live birth: _____			
6. Have you had any assisted pregnancies?			
7. Did you breastfeed your children and for how long?			
		Yes	No
8. Do you have lumps in your breasts?	Right		
	Left		
9. Do you have any discomfort pain or tenderness in your breasts?	Right		
	Left		
10. Do you have any skin retraction / thickening on your breasts?	Right		
	Left		
11. Do you have any nipple discharge?	Right		
	Left		
12. Have you had you have any previous breast surgery/biopsy?			
13. Have you had any other gynaecological surgery?			
14. Do you have any family history of breast or ovarian cancer? If yes who?			
14.1 Any other cancer in the family?			
15. Do you take any caffeine?			
16. Do you smoke/vape?			
17. Are you taking medication?			
18. Are you taking hormone replacements?			

19. Please indicate: Lumps ○ Scars ≡ Moles ☼

