Bethesda Women's Health Center
BAPTIST HEALTH SOUTH FLORIDA

Name: _____ **Date of birth:** _____**Age:**_____

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

Phone:_____

Height:_____ **Weight:**_____ **Age of First Period:**_____ **Age at Birth of 1st Child**____

Have you gone through menopause? YES or NO Age of menopause:___ **or Date of last period:**__

Have you ever used Hormone Replacement Therapy? YES or NO
How long ? _____ **If previous use, when did you quit taking?**_____

Please list physicians you would like to receive today's results:

PCP (Primary Care Physician)_____**OB/GYN:** _____

Other Physicians: _____

PLEASE answer **ALL** of the following questions. **CIRCLE** the appropriate answers and/or fill in the blanks.

1. ARE YOU PREGNANT NOW? YES NO

2. When was your last mammogram? _____ Where?_____

3. Did you experience discomfort during your last mammogram? 1 2 3 4 5
Minimal Moderate Severe

4. Why are you having this breast study? Routine/Yearly YES NO

Do you feel **ANY LUMPS TODAY**? YES NO RT LT How long_____
Breast Pain or soreness today? YES NO RT LT How long_____
Any Discharge from Nipple? YES NO RT LT Color or Discharge_____ How long_____
Any nipple changes on your breast? YES NO RT LT

5. Have you ever had breast cancer? YES NO

When?_____ What age?_____ Which breast(s) Right Left

Type of breast cancer? ❒ DCIS ❒ Invasive Ductal ❒ Invasive Lobular
Other_____

What surgery/treatment(s) did you have? ❒ Lumpectomy ❒ Mastectomy
❒ Radiation ❒ Chemotherapy ❒ Tamoxifen ❒ Evista ❒ Other _____

6. Have you had a breast biopsy or surgery for reasons **OTHER** than for breast cancer? YES NO

Type of surgery: ❒ Biopsy ❒ Implants ❒ Reduction ❒ Breast lift ❒ Other: _____

How many surgeries? Right_____ Left_____

When (year)? Right_____ Left_____

Result: ❒ Benign ❒ Hyperplasia ❒ Atypical Hyperplasia ❒ LCIS

7. What is your race? ❒ Caucasian ❒ African American ❒ Hispanic/Latino ❒ Asian
❒ Ashkenazi Jewish Other_____

Signature: _____**Date**_____

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PERSONAL INFORMATION			
Patient Name		Date of Birth	Age
Gender (M/F)	Today's Date	Healthcare Provider	Patient Phone Number

Please specify relative/<u>age of diagnosis as best you can</u>. Include family members from your mother's and father's side. If unsure of their age, give best estimate: 30's, 40's, 50's.

(Y)	N	**Example- Breast cancer before age 50**	Self	Mother's Side **Aunt-50**	Father's Side
Y	N	Breast cancer before age 50			
Y	N	Ovarian cancer at any age			
Y	N	Male breast cancer at any age			
Y	N	Breast cancer in both breasts or the same breast twice in 1 relative			
Y	N	Triple Negative (ER-, PR-, Her2-) breast cancer			
Y	N	**<u>2</u>** or more relatives on the SAME SIDE of the family with breast cancer, one diagnosed before age 50			
Y	N	**<u>3</u>** relatives with breast, prostate or pancreatic cancer on the **<u>same side of the family at any age</u>**		1. 2. 3.	1. 2. 3.
Y	N	Ashkenazi Jewish ancestry & breast or pancreatic cancer			
Y	N	Colon cancer at age 50 or younger			
Y	N	Uterine/endometrial cancer **at any age in yourself** or **under 50 in a family member**			
Y	N	**<u>3</u>** of the following **at any age**: Colon/Rectal Pancreatic Uterine/Endometrial Small bowel Ovarian Stomach Liver Kidney/renal Urinary tract/bladder Brain Sebaceous adenoma		1. 2. 3.	1. 2. 3.
Y	N	10 or more **pre-cancerous colon polyps** found in 1 person throughout their lifetime. Total # of Polyps:____			
		Any other breast cancers not listed above			

Y N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome?
If Yes, Who?_____What gene(s)? _____What was the result? _____Year tested?_____

OFFICE USE ONLY: Below to be completed by your Technologist

Patient meets criteria ☐ Y ☐ N
☐ Genetic Education provided ☐ Declined Genetic Education ☐ Test Sent ☐ Declined Testing

TYRER CUZICK (IBIS) _____% Patient Signature _____ Tech Initials _____