Name: ____ DOB: _______________

PAST MEDICAL HISTORY - Please check all the apply

[ ] Anemia
[ ] Asthma
[ ] Blood clots
[ ] Breast Cancer
[ ] Chemotherapy history
[ ] Cardiac stents or surgery
[ ] Diabetes
[ ] Heart attack
[ ] Heart Disease
[ ] Heart Murmur
[ ] Hypertension
[ ] Kidney disease
[ ] Sleep apnea
[ ] Stroke
[ ] Thyroid disease
[ ] Other Cancer
[ ] Other
____

Allergies to Medications: ____

Current Meds:
____

____

Previous Surgeries & year:
____

____

SOCIAL HISTORY

[ ] Current Tobacco Use [ ] Previous Tobacco Use Age started ________ Age quit: _______

How many alcoholic drinks per week _________________________

FAMILY HISTORY - Please check any that apply to your family

[ ] Abnormal bleeding
[ ] Blood Clots
[ ] Cancer _______________
[ ] Diabetes
[ ] Heart Attack
[ ] Heart Disease
[ ] Hypertension
[ ] Kidney disease
[ ] Stroke
[ ] Thyroid disease
[ ] Other

BREAST HISTORY - FEMALES ONLY (This information is used to determine your risk of developing breast cancer over your lifetime)

Age at Menses ______________ # of Pregnancies _______________ # of Births ____________
Age at first live birth ____________ Age at Menopause ___________ Years of breast feeding ____
# of first degree relatives with breast cancer (mother, sister, daughters) ______________
# of years with contraception __________ # of years of hormone replacement therapy _______
# of previous breast biopsies ___________ # of biopsies with ADH (atypical cells) __________
Race/Ethnicity: [ ] White [ ] African-American [ ] Hispanic [ ] American Indian/Alaskan Native
[ ] Chinese [ ] Japanese [ ] Filipino [ ]Hawaiian [ ] Pacific Islander [ ] Korean [ ] Vietnamese