EWBC MEDICAL HISTORY Please bring this form to your upcoming appointment or complete it online at ewbc.com within the patient portal. Please do not fax or mail.

1. Purpose of today’s visit: ____________________________________________________________

2. Occupation: _____________________________ 3. Gender: ☐ Male ☐ Female

4. Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner ☐ Legally Separated

5. How many months since your last clinical breast exam by a healthcare provider? ______

6. ☐ Birth control: method: __________________________ Name of Medication ____________ Dosage ______ # Years

7. ☐ Anti-Estrogen Breast Cancer Prevention: __________________________

8. Breast, please check if applies to you:

☐ Nipple implants: type: ☐ silicone gel ☐ saline ☐ combination ☐ unknown

☐ Nipple inversion: ☐ right ☐ left

☐ Nipple rash: ☐ right ☐ left

☐ Breast cysts: ☐ right ☐ left

☐ Nipple discharge: ☐ right ☐ left

☐ Breast pain: ☐ right ☐ left

☐ Year & Location of surgery

9. ☐ Breast surgery (see diagram) ☐ Bilateral mastectomy

☐ Breast Radiation to breast/chest area: dates __________________

☐ Chemotherapy: dates __________________

10. ☐ Breast cancer ☐ Bilateral breast cancer

11. Have you ever had a breast biopsy? ☐ No ☐ Yes If yes, number of breast biopsies _____

   ☐ ADH (atypical ductal hyperplasia) ☐ Duct Hyperplasia ☐ LCIS (lobular carcinoma insitu)

   ☐ ALH (atypical lobular hyperplasia)

12. ☐ My periods are regular 13. ☐ Are you post menopausal? ☐ No ☐ Yes, Age entered menopause ______

14. ☐ Hormone replacement: Usage: ☐ never ☐ unknown ☐ used over 5 yrs ago ☐ less than 5 yrs ago ☐ current

   Length of time on HRT: _____ months _____ years ______

15. Do you have biological children? ☐ No ☐ Yes If yes, Age had first child ______


19. Have you had both of your ovaries removed? ☐ No ☐ Yes 20. Do you have your uterus? ☐ No ☐ Yes

21. Smoking status: ☐ Current, every day ☐ Current, some day smoker ☐ Former smoker ☐ Never smoker ☐ Denied

   ☐ Smoker, current status unknown ☐ Unknown if ever smoked ☐ Heavy tobacco smoker ☐ Light tobacco smoker

22. Do you drink alcohol? ☐ No ☐ Yes: How often? ____________

23. Race: ☐ White ☐ African American ☐ American Indian or Alaska Native ☐ Asian

☐ Native Hawaiian or Pacific Islander ☐ Other, Race: __________________________

24. Ethnicity: ☐ Not Hispanic/Latino ☐ Hispanic/Latino

25. Preferred Language: ☐ English ☐ Other __________________________ 26. Height _____ Weight _____

27. PERSONAL HISTORY (please check if applies to you)

☐ Arthritis type: _____________________________ ☐ Heart Attack

☐ Asthma ☐ Heart valve/stent

☐ Bleeding Disorder ☐ Hepatitis A

☐ Depression ☐ Hepatitis B

☐ Diabetes ☐ Hepatitis C

☐ Eye problems ☐ High Blood Pressure

☐ Fever or Chills ☐ Joint aches

☐ Kidney problems ☐ Leg swelling

☐ Stomach problems ☐ Stroke

☐ Weakness/dizziness, fainting ☐ Leukemia

☐ Lymphoma ☐ Liver disease

☐ Pacemaker/defibrillator ☐ Seasonal allergies

8.31.17
28. Are you allergic to any of the following? (Please check if applies and specify reaction)
   - Medications
   - Iodine Contrast Material
   - Adhesive tape
   - Lidocaine
   - Latex
   - MRI Contrast
   - Other(s)

29. Do you take aspirin or blood thinners: please specify:

30. Other Current Medications (include non-prescription medications, write “none” if no medications are used)

31. HISTORY of CANCER (You & your relatives)
   Yourself, Mother, Father, Daughters, Sons, Brothers, Sisters, Aunts, Uncles, Grandmothers, Grandfathers, Granddaughters, Grandsons, female First Cousins, male First Cousins, Nieces & Nephews

<table>
<thead>
<tr>
<th>CANCER DIAGNOSIS</th>
<th>RELATIVE</th>
<th>Side of Family (mother or father)</th>
<th>Age at diagnosis</th>
<th>Age at recurrence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast*</td>
<td>Example: Colon</td>
<td>grandmother</td>
<td>mother</td>
<td>65</td>
</tr>
<tr>
<td>Colon</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastric</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leukemia</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lymphoma</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Melanoma</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ovarian</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pancreatic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prostate</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thyroid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uterine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Please list each different breast cancer diagnosis

32. Are you adopted? ☐ No ☐ Yes  
33. Are you of Ashkenazi Jewish descent? ☐ No ☐ Yes

34. Have you had GENETIC TESTING? ☐ No ☐ Yes: Where:________ Year:_____
   Result & for which gene:__________________________
   Has any member of your family had genetic testing? ☐ No ☐ Yes: Who:________ Where:________ Year:_____ Result and for which gene:__________________________
   Comments:_______________________________________________________________________________________________

The above information is accurate and any unanswered questions are considered not applicable or negative.

Print Name: ____________________________ Date of Birth: _____________ Today’s Date: ________________

Sign Name: ____________________________ E-Mail Address: ____________________________

Patient review____ Date: _______________ Patient review____ Date: _______________

FOR OFFICE USE ONLY ☐ All other systems negative

MD Review: __________ Date: ______ | MD Review: __________ Date: ______ | MD Review: __________ Date: ______