EWBC MEDICAL HISTORY *Please bring this form to your upcoming appointment* **MR#** _____

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: _____
7. ❑Anti-Estrogen Breast Cancer Prevention:

Name of Medication	Dosage	# Years

8. **Breast, *please check if applies to you:***

   ❑Breast implants: type: ❑silicone gel ❑saline ❑combination ❑unknown

   ❑Nipple inversion: ❑right ❑left

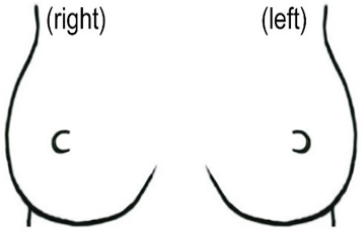
   ❑Nipple rash: ❑right ❑left

   ❑Breast cysts: ❑right ❑left

   ❑Nipple discharge: ❑right ❑left

   ❑Breast pain: ❑right ❑left

please indicate
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 _____
    Was the diagnosis?: ❑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_____
16. ❑Currently pregnant **17.** ❑Currently breastfeeding **18.** Age of first menstrual cycle____
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:_____
❑Asthma
❑Bleeding Disorder
❑Depression
❑Diabetes
❑Eye problems
❑Fever or Chills
❑Heart Attack
❑Heart valve/stent
❑Hepatitis A
❑Hepatitis B
❑Hepatitis C
❑High Blood Pressure
❑Joint aches
❑Kidney problems
❑Leg swelling
❑Leukemia
❑Lymphoma
❑Liver disease
❑Pacemaker/defibrillator
❑Seasonal allergies
❑Stomach problems
❑Stroke
❑Weakness/ dizziness, fainting

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. ❑I 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, Grandaughters, Grandsons, female First Cousins , male First Cousins, Nieces & Nephews

CANCER DIAGNOSIS		**RELATIVE**	***Side of Family*** ***(mother or father)***	***Age*** ***at diagnosis***	***Age*** ***at recurrence***
CANCER:	Example: Colon	grandmother	mother	65 ☒deceased	
*Breast**				❑deceased	
Colon				❑deceased	
Gastric				❑deceased	
Kidney				❑deceased	
Leukemia				❑deceased	
Lymphoma				❑deceased	
Melanoma				❑deceased	
Ovarian				❑deceased	
Pancreatic				❑deceased	
Prostate				❑deceased	
Thyroid				❑deceased	
Uterine				❑deceased	
**Please list each different breast cancer diagnosis*				❑deceased	

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: _____