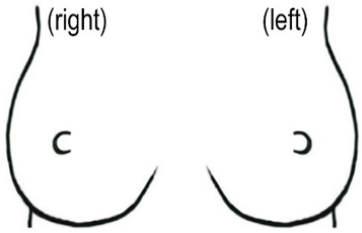
EWBC MEDICAL HISTORY *Please bring this form to your upcoming appointment* **MR#** _____

or complete it online at ewbc.com within the patient portal. Please do not fax or mail.

1. **Purpose of today's visit:** _____ 2. **Gender**: ❑Male ❑Female
3. **Marital Status:** ❑Single ❑Married ❑Divorced ❑Widowed ❑Domestic Partner ❑Legally Separated
4. **Occupation:** _____ 5. **Do you drink alcohol?** ❑No ❑Yes, how often: _____
6. **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
7. **Race:** ❑White ❑African American ❑American Indian or Alaska Native ❑Asian
   ❑Native Hawaiian or Pacific Islander ❑Other, race:_____
8. **Ethnicity**: ❑Not Hispanic/Latino ❑Hispanic/Latino **9. Preferred Language:** ❑English ❑Other_____
10. **Height** _____ **Weight** _____
11. **How many months since your last clinical breast exam by a healthcare provider?** _____
12. **Are you on Birth control?** ❑No ❑Yes, method: _____ brand: _____
13. *Please check box if you are **currently** experiencing*
    ❑Breast cysts ❑Breast pain ❑Nipple changes ❑Nipple Inversion ❑Nipple Discharge ❑Nipple rash
14. **Are you currently using Anti-Estrogen Breast Cancer Prevention**? ❑No ❑Yes, brand: _____
15. **Do you have breast implants:** ❑No ❑Yes, type: ❑silicone gel ❑saline ❑combination ❑unknown
16. **Are you currently pregnant** ❑No ❑Yes 17. **Are you currently breastfeeding** ❑ No ❑ Yes,
18. **Have you had breast surgery** ❑No (please skip to question 19)
    ❑ Yes (please mark on diagram to the right AND check off below what applies to you)
    - ❑**Reduction**? ❑Right ❑Left
    - ❑**Mastectomy**? ❑Right ❑Left ❑Bilateral
    - ❑**Lumpectomy**? ❑Right ❑Left
    - ❑**Breast Cancer?** ❑Right ❑Left ❑Bilateral
      - ❑**Radiation therapy** to your breast chest area, when? _____
      - ❑**Chemotherapy,** when? _____ for what? _____

please indicate
YEAR & LOCATION of surgery



19. **Have you ever had a breast biopsy?** ❑No ❑Yes, # of breast biopsies: _____
    Biopsy Results: (If unsure, please don't check)
    ❑Atypical Ductal Hyperplasia (ADH) ❑Lobular Carcinoma in situ (LCIS)
    ❑Ductal Hyperplasia (UDH) ❑Atypical Lobular Hyperplasia (ALH)
20. **Age of first menstrual cycle:** _____ **Are your periods regular** ❑No ❑Yes
21. **Are you post menopausal?** ❑No ❑Yes, age entered menopause: _____
22. **Hormone replacement**: ❑No ❑Yes, *usage:* ❑never ❑unknown ❑used over 5 years ago
    ❑less than 5 yrs ago ❑current **22b. *Length of time on HRT*:** _____ months _____ years
23. **Do you have biological children?** ❑No ❑Yes, age you were when you gave birth to your first child: _____
24. **Have you had *both* of your ovaries removed?** ❑No ❑Yes **24b. Do you have your uterus?** ❑No ❑Yes
25. **Are you allergic to any of the following?** (*Please check if applies to you and specify reaction)*
    ❑Medications _____ ❑Iodine contrast material _____ ❑Adhesive tape _____
    ❑Lidocaine _____ ❑Latex_____ ❑MRI Contrast ❑Other(s) _____
26. **Do you take aspirin or blood thinners**? ❑No ❑Yes, please specify:_____
27. **Other Current Medications** (include non-prescription medications, write "none" if no medications are used)

_____ _____ _____ _____

_____ _____ _____ _____

28. PERSONAL HISTORY (*please check if applies to YOU)*

❑Stroke	❑Hepatitis B	❑Bleeding Disorder	❑Kidney problems
❑Heart Attack	❑Hepatitis C	❑Depression	❑Leg swelling
❑High Blood Pressure	❑Liver Disease	❑Eye problems	❑Pacemaker/defibrillator
❑Asthma	❑Diabetes	❑Fever or Chills	❑Seasonal allergies
❑Hepatitis A	❑Arthritis	❑Heart valve/stent	❑Stomach problems
		❑Joint aches	❑Weakness/ dizziness, fainting

29. 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***
CANCERS TO LIST ON THIS CHART: *Breast* Colon Gastric Kidney Leukemia Lymphoma Melanoma Ovarian Pancreatic Prostate Thyroid Uterine* **Please list each different breast cancer diagnosis*	Example: Colon	grandmother	mother	65 ☒deceased	
				❑deceased	
				❑deceased	
				❑deceased	
				❑deceased	
				❑deceased	
				❑deceased	
				❑deceased	
				❑deceased	
				❑deceased	

30. Are you adopted? ❑No ❑Yes **31. Are you of Ashkenazi Jewish descent?** ❑No ❑Yes.

32. Have you had GENETIC TESTING for cancer risk? ❑No ❑Yes, where:_____ Year:_____
Result & for which gene? _____
Has any member of your family had genetic testing for cancer risk? ❑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: _____