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 ❑Gender not listed **3. Sex assigned at birth** (if different) ❑Male ❑Female ❑Intersex

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

5. **Occupation:** ____________________ **6. Do you drink alcohol?** ❑No ❑Yes, how often: ________________

7. **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

8. **Race:** ❑White ❑African American ❑American Indian or Alaska Native ❑Asian
❑Native Hawaiian or Pacific Islander ❑Other, race:_________________ **9. Height** _______ **Weight** ______

10. **Ethnicity**: ❑Not Hispanic/Latino ❑Hispanic/Latino **11. Preferred Language:** ❑English ❑Other_________

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

13. **Are you on Birth control?** ❑No ❑Yes, method: _________________ brand: _________________

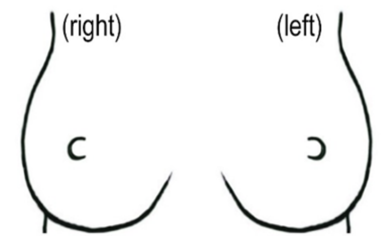
14. *Please check box if you are **currently** experiencing:*
❑Breast cysts ❑Breast pain ❑Nipple changes ❑Nipple Inversion ❑Nipple Discharge ❑Nipple rash

15. **Are you currently using Anti-Estrogen Breast Cancer Prevention**? ❑No ❑Yes, brand: _________

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)
❑**Breast implants?** type: ❑silicone gel ❑saline ❑combination ❑unknown
❑**Reduction?**
❑**Mastectomy?** ❑Right ❑Left ❑Bilateral
❑**Double incision top surgery?**
❑**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:___________________________________

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27. Current Medications (include non-prescription medications, write "none" if no medications are used)

________________________ ________________________ ________________________ ________________________

________________________ ________________________ ________________________ ________________________

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

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

29. HISTORY of CANCER *(YOU & your relatives)*
Yourself, Mother, Father, Daughters, Sons, Brothers, Sisters, Aunts, Uncles, Grandmothers, Grandfathers, Grandaughters, Grandsons, Nieces & Nephews

	CANCER TYPE	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	M	45 ☒deceased	
				❑deceased	
				❑deceased	
				❑deceased	
				❑deceased	
				❑deceased	
				❑deceased	
				❑deceased	
				❑deceased	
				❑deceased	

30. Are you adopted? ❑No ❑Yes **31. Are you of Ashkenazi Jewish descent** (at least 10% or more)? ❑No ❑Yes.

32. Have you previously pursued Genetic Testing for your Cancer Risk outside of EWBC? ❑No ❑Yes

If YES please indicate where you were tested and the results: ______________________________

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

First Name (print):________________________ Last Name (print):____________________ Sign Name:________________________

Name you would like to be addressed by if different than above:______________________________ Date of Birth: ________

Today's Date: ____________ E-Mail Address: ____

Patient review_______ Date: _________________ Patient review_______ Date: _________________

FOR OFFICE USE ONLY ❑ **All other systems negative**
MD Review: ______________________ **Date:** ______ | **MD Review:** ______________________ **Date:** ______