Elizabeth Wende Breast Care
Breast Imaging Excellence

HEALTH HISTORY FORM

for new patients
unable to complete independently

PLEASE NOTE: This form is for new patients only. Please fill this out only if it can't be filled out over the phone with a staff member (585-442-2190) or at our office at the appointment on one of our computer kiosks. Staff would happy to assist filling out form, over the phone or in the office.

Name:_____ **Date:** _____

Purpose of today's visit?

Social History:

Gender? ❑Female ❑Male ❑Gender not listed ❑Intersex

Sex assigned at birth? (If different) ❑Female ❑Male ❑Gender not listed ❑Intersex

Marital Status? ❑Single ❑Married ❑Divorced ❑Domestic Partner ❑Widowed ❑Legally Separated ❑Decline

Occupation?

Do you drink alcohol? ○ Yes ○ No How often?

Do you smoke? ❑Never ❑Former ❑Current everyday ❑Current some day ❑Heavy tobacco ❑Light tobacco ❑Smoker, current status unknown ❑Unknown if ever smoked ❑Decline to specify

Race(s): ❑White ❑Black or African American ❑American Indian or Alaska Native ❑Asian ❑Native Hawaiian or other Pacific Islander ❑Other, race:_____ ❑Decline to specify

Ethnicity: ❑Not Hispanic/Latino ❑Hispanic/Latino ❑Decline to specify

Preferred Language: ❑English Other:

Height:

Weight:

Are you allergic to any of the following:

Medication allergies? ○ Yes ○ No Please list all medication allergies:

Adhesive Tape? ○ Yes ○ No

Lidocaine? ○ Yes ○ No

Iodine Contrast Material? ○ Yes ○ No

Latex? ○ Yes ○ No

Others?

Do you currently have any of the following:

Nipple changes

Inversion? ○ Yes ○ No

Discharge? ○ Yes ○ No

Do you have any of the following:

Pacemaker / Defibrillator? ○ Yes ○ No

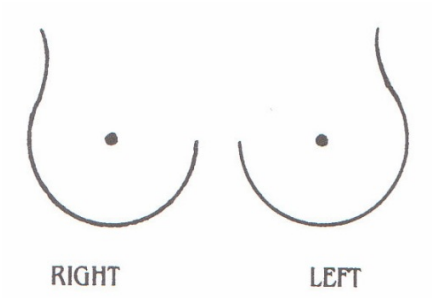
Heart valve / Stent? ○ Yes ○ No

Breast History:

Have you had breast surgery? ○ Yes ○ No

- Breast Implants? ○ Yes ○ No
- Breast Reduction? ○ Yes ○ No
- Lumpectomy? ○ Yes ○ No
- Mastectomy? ○ Yes ○ No
- Double Incision Top Surgery? ○ Yes ○ No
- Fat Transfer/Grafting? ○ Yes ○ No When? _____ ○ Left ○ Right ○ Bilateral

Please indicate where you had surgery with an "X"



Radiation therapy to your breast/chest area? ○ Yes ○ No When? _____

Chemotherapy? ○ Yes ○ No When? _____ For What? _____

Have you ever had a breast biopsy? ○ Yes ○ No

Number of breast biopsies: _____

Were the biopsy results with:

- Atypical Ductal Hyperplasia (ADH)? ○ Yes ○ No **(If unsure, please answer 'No')**
- Lobular Carcinoma in situ (LCIS)? ○ Yes ○ No **(If unsure, please answer 'No')**
- Ductal Hyperplasia (UDH)? ○ Yes ○ No **(If unsure, please answer 'No')**
- Atypical Lobular Hyperplasia (ALH)? ○ Yes ○ No **(If unsure, please answer 'No')**

Medications:

Are you taking aspirin or blood thinners? ○ Yes ○ No

List all medications you are taking: *(include non-prescription medications and birth control pills, **write 'none' if no medications are used**)*

Questions for female patients:

How many months since your physician examined your breasts?

Do you have biological children? ○ Yes ○ No Your age at birth of your 1st child: _____

Your age at time of 1st menstrual cycle: _____

Are you Post-menopausal? ○ No Age you entered menopause: _____ ☐ Unknown

(If you are no longer having periods for at least one year)

Are your periods regular? ○ Yes ○ No

Do you have your uterus? ○ Yes ○ No

Have you had your ovaries removed? ○ Yes ○ No Comment: _____

Hormone replacement therapy: ❑Never ❑Unknown ❑Previous user(over 5 years ago) How long on it: ❑Previous user(less than 5 years) How long on it: ❑Current User How long on it:

Are you taking:

Birth control? ○ Yes ○ No Method: _____ Brand: _____

Anti-Estrogen/Breast Cancer Prevention? ○ Yes ○ No Brand: _____

Are you breast feeding? ○ Yes ○ No Are you pregnant? ○ Yes ○ No

Risk Factors:

Are you adopted? ○ Yes ○ No

Are you of Ashkenazi Jewish Descent (at least 10%)? ○ Yes ○ No

Have you previously pursued Genetic Testing for your Cancer Risk? ○ Yes ○ No

If outside of EWBC, Please indicate where and results:

Personal conditions:

No Conditions: ☐

	Condition	Age at onset	Age at recurrence	Type
☐	Breast cancer			
☐	Secondary Breast Cancer			
☐	Ovarian cancer			
☐	Prostate cancer			
☐	Melanoma			
☐	Pancreatic cancer			
☐	Kidney cancer			
☐	Colon cancer			
☐	Uterine cancer			
☐	Thyroid cancer			
☐	Gastric cancer			

☐ Lymphoma
☐ Leukemia
☐ Stroke
☐ Heart Attack
☐ High Blood Pressure
☐ Asthma
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C
☐ Autoimmune Disease
☐ Liver Disease
☐ Diabetes
☐ Arthritis
☐ Bleeding Disorder

Comments regarding personal risk factors:

Blood relatives: Mother, Father, Daughters, Sons, Brothers, Sisters, Aunts, Uncles, Grandmothers, Grandfathers, Granddaughters, Grandsons, Nieces & Nephews

Blood relatives with risk factors? ○ Yes ○ No known family history

Relative 1

Type of Relative: _____

Deceased: ☐ Age at death: _____

Condition	Age at onset	Age at recurrence	Type
☐ Breast cancer			
☐ Secondary Breast Cancer			
☐ Ovarian cancer			
☐ Prostate cancer			
☐ Melanoma			
☐ Pancreatic cancer			
☐ Kidney cancer			
☐ Colon cancer			
☐ Uterine cancer			
☐ Thyroid cancer			
☐ Gastric cancer			
☐ Lymphoma			
☐ Leukemia			

Comments regarding relative 1

Relative 2

Type of Relative: _____

Deceased: ☐ Age at death: _____

Condition	Age at onset	Age at recurrence	Type
☐ Breast cancer			
☐ Secondary Breast Cancer			
☐ Ovarian cancer			
☐ Prostate cancer			
☐ Melanoma			
☐ Pancreatic cancer			
☐ Kidney cancer			
☐ Colon cancer			
☐ Uterine cancer			
☐ Thyroid cancer			
☐ Gastric cancer			
☐ Lymphoma			
☐ Leukemia			

Comments regarding relative 2

Please make note about any additional relatives with conditions (include age at onset, recurrence and type)

Relative 3

Relative 4

Relative 5