

WOMEN'S HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____ Date: _____

- At what age did you have your first menses (started your period?) _____
- Is your current menses regular? _____
- How many times have you been pregnant? _____
- How old were you when you had your first child? _____
- How many children have you delivered? _____
- How many, if any, abortions or miscarriages have you had? _____
- Did you breast-feed your children and for how long? _____
- Have you ever been on birth control pills and for how long cumulatively? _____
- Is there a possibility that you may be pregnant now? _____
- Have you in the past, or are you currently, taking estrogen or progesterone?
If so, for how long? _____
- Have you ever had any previous breast biopsies?
If so, by whom and where? _____
- Does anyone in your family (maternal or paternal) have a history of breast cancer?
(Please specify family member(s)): _____

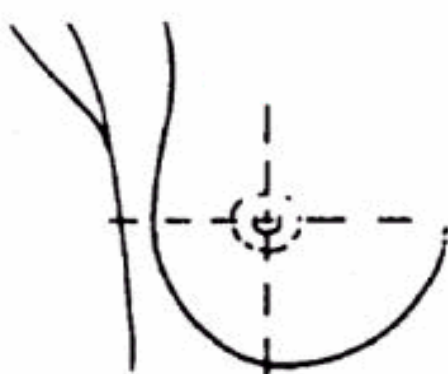
If so:

How old were they when they were diagnosed? _____

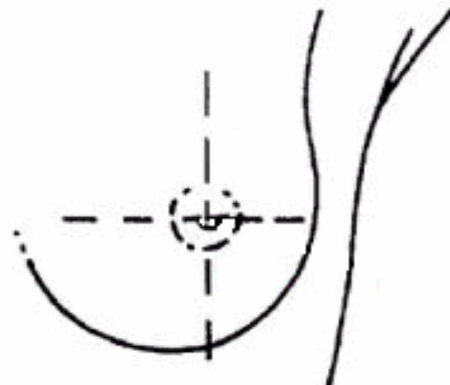
What kind of treatment did they receive? _____

Did they die from their disease? _____

- Please mark the area of concern on the diagram below:



Right Breast



Left Breast