

Breast Health History – Initial Visit

Name: _____ Age: _____ Date of Birth: _____

Address: _____ City: _____ Postal Code: _____

Cell: _____ Home: _____ E-mail: _____

Occupation: _____ Marital Status: S M D W SEP # of Children: _____

Y N Do you have a family history of breast cancer?
 Self Mother Maternal Grandmother Sister Daughter None

Y N Do you have any diagnosed breast conditions?
 None Fibrocystic Cystic Other _____

Y N Have you previously had a thermogram? Date of most recent _____
Was it: Normal Abnormal Suspicious Being watched R L Breast

Y N Have you had a mammogram? Date of most recent _____
Was it: Normal Abnormal Suspicious Being watched R L Breast

Y N Have you had a breast ultrasound? Date of most recent _____
Was it: Normal Abnormal Suspicious Being watched R L Breast

Y N Have you had a breast exam by a doctor? Date of most recent _____
Was it: Normal Lump Found R L Breast

Y N Any breast biopsies? When and what type (i.e. needle, core)? _____ R L Breast

Y N Any breast surgeries? When and what was done? _____ R L Breast

Y N Have you had a mastectomy? When? _____ R L Breast

Y N Have you had radiation? When was it last performed? _____ R L Breast

Y N Have your had your ovaries removed? At what age? _____

Y N Do you have children. At what age was your first full term pregnancy? _____

Y N Did you nurse for at least three months? How long _____

Y N Are you currently nursing?

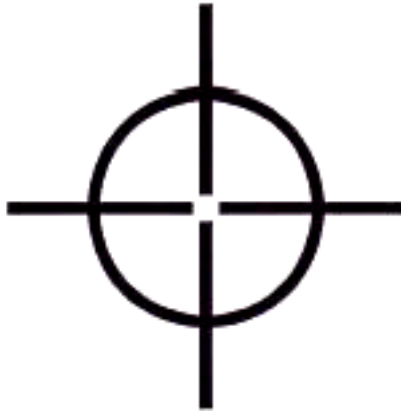
- Y N Are you currently pregnant?
- Y N Are you currently taking birth control pills?
At what age did you start? _____ for how many years? _____
- Y N Are you in menopause? At what age did it begin? _____
- Y N Have you ever taken synthetic hormone replacement (ex. Premarin, Provera)?
How many years taken? _____
- Y N Are you currently using natural progesterone cream?
Applied to Breasts only Rotating body areas
- Y N Are you currently using herbals, homeopathic medicines, or supplements to stimulate or simulate estrogen? Explain _____
- Y N Do you feel that you are overweight? How many pounds overweight? _____

Are you experiencing any of the following with your breasts?

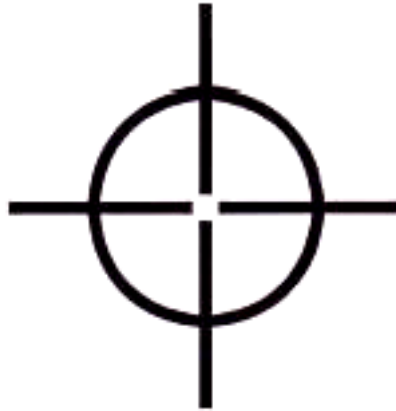
- Y N A lump. Date found: _____ by Self Doctor R L Breast
It is: Hard Soft Mobile Tender
- Y N Pain R L Breast
It is Dull Sharp Burning Stinging Tender Changes with my cycle
- Y N Thickening R L Breast
- Y N Skin changes (Color Texture Over the lump)
- Y N Nipple discharge R L Breast
It is Bloody Milky Through one duct through multiple ducts
- Y N Nipple retraction R L Breast
- Y N Nipple changes R L Breast
Change in: Color Texture
- Y N Other _____

Please note any other concerns/issues you may have: _____

Place an [O] on the diagram in the exact area of the lump, findings on your mammogram, or area being watched, and a [X] in the area of pain, tenderness, thickening, or skin changes.



Right Breast



Left Breast

General Health Information

Y N Do you have any medical complaints or conditions? Please explain _____

Y N Are you currently taking any medications? Please list _____

Please circle all of the following conditions which you have had:

- | | | | | | |
|-------------|-------------|------------------|-----------------------------|-----------------|----------------|
| Abscesses | Depression | Heart Disease | Mononucleosis | Rheumatic Fever | Syphilis |
| Addiction | Diabetes | Hepatitis | Mumps | Rubella | Tonsillitis |
| Allergies | Emphysema | Herpes Genitalia | Parasites | Scarlet Fever | Tuberculosis |
| Amnesia | Epilepsy | Influenza | Pelvic Inflammatory Disease | Sexual Abuse | Typhoid Fever |
| Arthritis | Gall Stones | Kidney Disease | Disease | Skin Disease | Venereal Warts |
| Asthma | Goiter | Leukemia | Peritonitis | Strep Throat | Warts |
| Cancer | Gonorrhea | Malaria | Pleurisy | Sinusitis | Whooping Cough |
| Chicken Pox | Gout | Measles | Pneumonia | Sunstroke | Worms |
| Cold Sores | Hay Fever | Miscarriage | Prostatitis | Stroke | Yellow Fever |
| Other _____ | | | | | |

Healthworks

NUTRITION CENTRE

Y N Are there any of the preceding conditions after which you have never been totally well again, or which have been more severe than usual? Explain? _____

Y N Have you had any operations? Which _____

Y N Have you lost any weight recently? How many pounds? _____

Y N Do you exercise? How often? _____

Y N Have you had any major injuries? Explain _____

Y N Are you taking any of the following substances? How much?

Tobacco: _____ Alcohol: _____

Coffee: _____ "Recreational Drugs" _____

Y N Have any of the following ailments affected your relatives?

- | | | | | | |
|------------|------------|-----------|---------------|----------------|--------------|
| Alcoholism | Asthma | Diabetes | Gout | Mental Illness | Skin Disease |
| Allergies | Cancer | Epilepsy | Hay Fever | Paralysis | Syphilis |
| Arthritis | Depression | Gonorrhea | Heart Disease | Pneumonia | Tuberculosis |

FAMILY HISTORY	Age, if Alive	Age at Death	AILMENTS
Mother:			
Father:			
Brothers:			
Sisters:			
Children:			
Maternal Grandmother:			
Maternal Grandfather:			
Paternal Grandmother:			
Paternal Grandfather:			

Signature: _____ Date: _____