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WOMEN'S HISTORY FORM

NAME:

D.O.B.:

AGE:

GYNECOLOGIST:

LAST EXAM:

DO YOU STILL MENSTRUATE?

PERIODS REGULAR?

WHEN WAS YOUR LAST MENSTRUAL PERIOD?

WHAT AGE DID YOU BEGIN TO MENSTRUATE?

HAVE YOU HAD A HYSTERECTOMY? IF YES, WHY?

DO YOU HAVE ANY BIOLOGICAL CHILDREN? IF SO, HOW OLD ARE THEY?

HOW MANY TIMES HAVE YOU BEEN PREGNANT? YOUR AGE AT FIRST BIRTH?

HAVE YOU EVER TAKEN BIRTH CONTROL PILLS OR ANY TYPE OF HORMONE THERAPY?

HAVE YOU EVER HAD A MAMMOGRAM?

IF SO, WHEN/ WHERE?

DO YOUR BREASTS CHANGE W/ YOUR MENSTRUAL CYCLE? HOW?

DID YOU BREASTFEED ANY OF YOUR CHILDREN? IF YES, HOW LONG?

HOW OFTEN DO YOU DO SELF BREAST EXAMINATIONS?

DO YOU HAVE ANY PERSONAL HISTORY OF BREAST DISEASE? ANY INFECTIONS, CANCER, PRE-MALIGNANT CHANGES, BIOPSIES, ASPIRATIONS OR SURGERIES? WHEN? PLEASE EXPLAIN.

HAVE YOU NOTICED ANY CHANGES IN YOUR BREAST (APPEARANCE, PAIN, SIZE, SHAPE, NIPPLE DISCHARGE)?

HAS ANYONE IN YOUR FAMILY (BLOOD RELATIVES) HAD ANY BREAST OR GYNECOLOGICAL CANCERS OR DISEASES? AGE OF ONSET? TREATMENT? CHEMOTHERAPY, RADIATION, SURGERY? PLEASE EXPLAIN.

SIGNATURE

DATE: