**PLEASE BRING FORM (DO NOT FAX OR MAIL)** AT TIME OF YOUR APPOINTMENT OR IF YOU PREFER **YOU MAY FILL THIS FORM OUT ONLINE AT EWBC.COM** (GO TO PATIENT PORTAL). THANK YOU.

## EWBC MEDICAL HISTORY FORM

— please remember to sign the back of this form AND only use ink to fill out this form—

| 1. Purpos   | se of today's visit           | :?            |               |              |               |                  |           |                |                  |                 |           |
|-------------|-------------------------------|---------------|---------------|--------------|---------------|------------------|-----------|----------------|------------------|-----------------|-----------|
| 2. Do you   | ı use:                        |               |               |              |               |                  |           |                |                  | If discontinued |           |
|             | a. Hormones?                  | Yes           | No            | Brand .      |               |                  |           |                |                  | when?           | _         |
|             | b. Oral Contrace              | •             | Yes           | No           | Brand $\_$    |                  |           |                |                  | -               |           |
|             | c. Anti-Estrogen              |               | ancer Prev    | ention?      | Yes           |                  |           |                |                  |                 |           |
| •           | ı have breast im <sub>l</sub> |               | Yes           | No           | (type)        | Silicone (       | Gel       | Saline         | Combinati        | ion Unknown     |           |
| -           | u taking aspirin              |               |               | Yes          | No            |                  |           |                |                  |                 |           |
| 5. Are yo   | ou allergic to any            | of the fol    | lowing?       |              |               |                  |           |                |                  |                 |           |
|             | a. Medicine(s)?               |               | Yes           | No           | (type) _      |                  |           |                |                  |                 |           |
|             | b. Adhesive Tap               | e?            | Yes           | No           |               |                  |           |                |                  |                 |           |
|             | c. Lidocaine?                 |               | Yes           | No           |               |                  |           |                |                  |                 |           |
|             | d. Iodine Contra              | ast Materi    | al? Yes       | No           |               |                  |           |                |                  |                 |           |
|             | e. Latex?                     |               | Yes           | No           |               |                  |           |                |                  |                 |           |
|             | f. Others?                    |               |               |              |               |                  |           |                |                  |                 |           |
| 6. Do you   | u currently have              | any of the    | e followin    | g? – pleas   | e check or    | ıly those th     | at app    | ly to you      | and explain b    | pelow:          |           |
|             | Fever/Chills                  |               | We            | akness       |               | Leg S            | welling   | 3              | Seaso            | onal Allergies  |           |
|             | Eye Problem                   | าร            | Dep           | ression      |               | Joint            | Aches     |                | Stom             | nach Problems   |           |
|             | Kidney Prob                   | olems         | Exp           | lanation     |               |                  |           |                |                  |                 |           |
| 7.0         |                               |               |               |              |               |                  |           |                | OFFI             | CE All othe     | r systems |
| -           | ons for female pa             |               | -             |              |               | t                | 2         |                | USE              | ONLY negative   | :         |
|             | 1. How many m                 |               |               |              |               |                  |           |                | iontns           |                 |           |
|             | 2. Your age at b              | -             |               |              |               | ogical child     | iren      |                |                  |                 |           |
|             | 3. Your age at ti             |               |               | l cycle      |               |                  |           |                |                  |                 |           |
|             | a. Are your po                | _             |               | /16          | Yes           |                  |           |                |                  |                 |           |
|             | 4. Age you ente               |               | pause         | (If you      |               | -                | g perio   | ds for at      | least one yea    | ar).            |           |
|             | 5. Are you preg               |               |               |              | Yes           | No               |           | 1              |                  | 1               |           |
|             | 6. Are you breas              | _             |               |              | Yes           | No               |           | (RIGHT)        |                  | (LEFT)          |           |
|             | 7. Do you have                | -             |               |              | Yes           | No               | /         |                |                  | \               |           |
|             | 8. Do you have                | -             |               |              | Yes           | No               | 1         | _              |                  | - \             |           |
|             | 9. Have you had               | d breast su   | rgery?        |              | Yes           | No               | 1         | C              | / \              | 5               |           |
|             |                               |               |               |              | , ,           |                  | \         |                |                  |                 |           |
|             | If yes, pl                    | lease mark ti | ne area of su | rgery with t | he year it wo | as done.         |           |                |                  |                 |           |
|             | 10. Have you ev               | er had rad    | liation the   | erapy to y   | our breas     | t/chest are      | ea?       | Yes            | No               |                 |           |
|             | if yes, v                     | when?         |               |              |               |                  |           |                |                  |                 |           |
|             | 11. Have you ev               | er had ch     | emothera      |              | Y             | es No            | )         | if yes, v      | vhen?            |                 |           |
|             | for wh                        | at?           |               |              |               |                  |           |                |                  |                 |           |
| 0.6         | r                             |               |               |              |               |                  |           |                |                  |                 |           |
|             | History: Ma                   |               | male          | $\square$    |               |                  | _         | ¬              |                  |                 |           |
|             | Marital Status:               | Single        | Mar           | ried         | Divorced      | Part             | ner       | _ Widov        | ved              |                 |           |
|             | Occupation:                   |               |               |              |               |                  |           |                |                  |                 |           |
|             | Do you drink ald              | cohol?        | Yes           | No           |               |                  |           |                |                  |                 |           |
|             | if yes, how often             | 1?            |               |              |               |                  |           |                |                  |                 |           |
|             | moke? check one               |               |               | Occasion     | al 🗆 N        | ever Smok        | ed [      | Forme          | r Smoker         | Unknown         |           |
| ,           |                               |               | <i>′</i> —    |              | _             |                  |           | _              |                  | Onknown         |           |
|             | _                             | rican India   |               | laska Nat    |               |                  | DIACK     | or Airica      | n American       |                 |           |
|             |                               | e Hawaiia     |               |              |               | nite             |           |                |                  |                 |           |
|             | Ethnicity:                    | Hispanic (    | or Latino     | ∐ N          | ot Hispan     | ic or Latin      | 0         |                |                  |                 |           |
|             | Preferred Langu               | age:          | English       | Ot           | ther          |                  |           |                |                  |                 |           |
| Dlosse Her  | - madiaatia "                 | -14           |               | - d: ·       |               | . t 1 · '11      | "         | <i>"</i> : C * |                  | 1)              |           |
| riease list | t medications (in             | ciuae non-pr  | escriptioi n  | eaications a | ana birth cor | itroi pills, wri | te "none' | if no n di     | cations are usea | 1)              |           |
|             |                               |               |               |              |               |                  |           |                |                  |                 |           |
|             |                               |               |               |              |               |                  |           |                |                  |                 | (over)    |

| ignature: Date: Date: Date: Date:  |                       |               |                  | -             | -      | one in your family has had | this problem. |  |
|--|-----------------------|---------------|------------------|---------------|--------|----------------------------|---------------|--|
| Breast Cysts Breast Pain Nipple Changes Inversion:   | Circuit Sci.          |               | -                |               | -      | ) p                        |               |  |
| Breast Pain Nipple Changes Inversion:  | Breast Cysts          |               |                  |               | IAMILI |                            |               |  |
| Nipple Changes Inversion:  |                       |               |                  | H             |        |                            |               |  |
| Inversion:   |                       | ~~~           |                  |               |        |                            |               |  |
| Discharge  |                       |               | Dista            |               |        |                            |               |  |
| Rash:  |                       | = =           | - ;              |               |        |                            |               |  |
| Heart Attack   Heart Attack  | •                     |               | - :              |               |        |                            |               |  |
| Heart Valve Replacement High Blood Pressure Pacemaker/Cardiac Stent Heart Attack Stroke Hepatitis/Liver Problems Asthma Diabetes Arthritis Hives Pancreatic Cancer Melanoma Lymphoma Leukemia Other Cancers (/Paceus list breast and ournian history below) Have you ever been tested for BRCA1/BRCA2 Mutations? (/Paceus list breast and ournian history below) Have you ever been tested for BRCA1/BRCA2 Mutations? (/Paceus list breast and ournian history below) Have you ever been tested for BRCA1/BRCA2 Mutations? (/Paceus list breast and ournian history below) Have you ever been tested for BRCA1/BRCA2 Mutations? (/Paceus list breast and ournian history below) Have you ever been tested for BRCA1/BRCA2 Mutations? (/Paceus list breast and ournian history below) Have you ever been tested for BRCA1/BRCA2 Mutations? (/Paceus list breast and ournian history below) Have you ever been tested for BRCA1/BRCA2 Mutations? (/Paceus list breast and ournian history below) Have you ever been tested for BRCA1/BRCA2 Mutations? (/Paceus list breast and ournian history below)  Have you ever been tested for BRCA1/BRCA2 Mutations? (/Paceus list breast and ournian history below)  Have you ever been tested for BRCA1/BRCA2 Mutations? (/Paceus list breast and ournian history below)  Have you ever been tested for BRCA1/BRCA2 Mutations? (/Paceus list breast and ournian history below)  Have you ever been tested for BRCA1/BRCA2 Mutations? (/Paceus list breast and ournian history below)  Have you ever been tested for BRCA1/BRCA2 Mutations? (/Paceus list breast and ournian history below)  Have you ever been tested for BRCA1/BRCA2 Mutations? (/Paceus list breast and ournian history below)  Have you ever been tested for BRCA1/BRCA2 Mutations? (/Paceus list breast and ournian history below)  Have you ever been tested for BRCA1/BRCA2 Mutations? (/Paceus list breast and ournian history below)  Have you ever been tested for BRCA1/BRCA2 Mutations? (/Paceus list breast and ournian history below)  Have you ever been tested for BRCA1/BRCA2 Mutations? (/Paceus list  |                       | Left L        | Right            |               |        |                            |               |  |
| High Blood Pressure Pacemaker/Cardiac Stent Heart Attack Stroke Hepatitis/Liver Problems Asthma Diabetes Arthritis Hives Pancreatic Cancer Melanoma Lymphoma Leukemia Other Cancers (Please list breast and ovarian history helow)  Have you ever been tested for BRCA1/BRCA2 Mutations? (Please list breast and ovarian history helow)  Have you ever been tested for BRCA1/BRCA2 Mutations? (Please list breast and ovarian history helow)  Have you ever been tested for BRCA1/BRCA2 Mutations? (Please list breast and ovarian history helow)  Have you ever been tested for BRCA1/BRCA2 Mutations? (Please list breast and ovarian history helow)  Have you ever been tested for BRCA1/BRCA2 Mutations? (Please list breast and ovarian history helow)  Have you ever been tested for BRCA1/BRCA2 Mutations? (Please list breast and ovarian history helow)  Have you ever been tested for BRCA1/BRCA2 Mutations? (Please list breast and ovarian history helow)  Have you ever been tested for BRCA1/BRCA2 Mutations? (Please list breast and ovarian history helow)  Have you ever been tested for BRCA1/BRCA2 Mutations? (Please list breast and ovarian history helow)  Have you ever been tested for BRCA1/BRCA2 Mutations? (Please list breast and ovarian history helow)  Have you ever been tested for BRCA1/BRCA2 Mutations? (Please list breast and ovarian history helow)  Have you ever been tested for BRCA1/BRCA2 Mutations? (Please list breast and ovarian history helow)  Have you ever been tested for BRCA1/BRCA2 Mutations? (Please list breast and ovarian history helow)  Have you ever been tested for BRCA1/BRCA2 Mutations? (Please list breast and ovarian history helow)  Have you ever been tested for BRCA1/BRCA2 Mutations? (Please list breast and ovarian history helow)  Have you ever been tested for BRCA1/BRCA2 Mutations? (Please list breast and ovarian history helow)  Have you ever been tested for BRCA1/BRCA2 Mutations? (Please list breast and ovarian history helow)  Have you ever been tested for BRCA1/BRCA2 Mutations? (Please list breast and ovarian history helow)   |                       |               |                  |               |        |                            |               |  |
| Pacemaker/Cardiac Stent  |                       | •             |                  |               |        |                            |               |  |
| Heart Attack  Stroke Hepatitis/Liver Problems Asthma Diabetes Arthritis Hives Pancreatic Cancer Melanoma Lymphoma Leukemia Other Cancers (Please list breast and ovarian history below) Have you ever been tested for BRCA1/BRCA2 Mutations? NO   YES   If yes, were the results:   Positive   Negative   Uncertain Variant Are you of Ashkenazi Jewish Ancestry?   NO   YES HISTORY OF BREAST CANCER:   NO   YES   YES Age at diagnosed with a second NEW breast Cancer Sister   Daughter   Sister   Daughter   Father   Sister   Daughter   Date:   Date:   Sister   Date:   Date:   Date:   Sister   Date:   Patient Review:   Date:   Signature:    | _                     |               |                  |               |        |                            |               |  |
| Stroke   | Pacemaker/C           | Cardiac Stent |                  |               |        |                            |               |  |
| Hepatitis/Liver Problems  Asthma Diabetes Arthritis Hives Pancreatic Cancer Melanoma Lymphoma Leukemia Other Cancers (**Please list breast and ovarian history below) Have you ever been tested for BRCA1/BRCA2 Mutations?   NO   YES   flyes, were the results:   Positive   Negative   Uncertain Variant Are you of Ashkenazi Jewish Ancestry?   NO   YES HISTORY OF BREAST CANCER:   NO   YES   Age at diagnosis Self Mother Sister   Daughter   HISTORY OF OVARIAN CANCER:   Brother   Father   Side (**Add Chical) No   YES   Father   Father   Side (**Add Chical) Nicee   Father   Father   Father   Sister   Daughter   Father   Sister   Sister   Daughter   Father   Sister   Si | Heart Attack          |               |                  |               |        |                            |               |  |
| Hepatitis/Liver Problems  Asthma Diabetes Arthritis Hives Pancreatic Cancer Melanoma Lymphoma Leukemia Other Cancers (**Please list breast and ovarian history below) Have you ever been tested for BRCA1/BRCA2 Mutations?   NO   YES   flyes, were the results:   Positive   Negative   Uncertain Variant Are you of Ashkenazi Jewish Ancestry?   NO   YES HISTORY OF BREAST CANCER:   NO   YES   Age at diagnosis Self Mother Sister   Daughter   HISTORY OF OVARIAN CANCER:   Brother   Father   Side (**Add Chical) No   YES   Father   Father   Side (**Add Chical) Nicee   Father   Father   Father   Sister   Daughter   Father   Sister   Sister   Daughter   Father   Sister   Si | Stroke                |               |                  |               |        |                            |               |  |
| Asthma Diabetes Arthritis Hives Pancreatic Cancer Melanoma Lymphoma Leukemia Other Cancers (Please list breast and ovarian history below) Have you ever been tested for BRCA1/BRCA2 Mutations?   NO  |                       | er Problems   | H                |               |        | type·                      |               |  |
| Diabetes Arthritis Hives Pancreatic Cancer Melanoma Lymphoma   | -                     | er i robierns |                  | H             |        | турс                       |               |  |
| Arthritis Hives Pancreatic Cancer Melanoma Lymphoma Lymphoma Lymphoma Leukemia Other Cancers (Please list breast and ovarian history below)  Have you ever been tested for BRCA1/BRCA2 Mutations? NO YES If yes, were the results: Positive Negative Are you of Ashkenazi Jewish Ancestry? NO YES HISTORY OF BREAST CANCER NO YES Age at diagnosis Self Mother Sister Daughter Brother Sister Son Niece Father's side Grandmother Grandmother Grandmother Mother Grandmother Mother Mother Mother Mother Mother Grandmother Mother Mother Mother Mother Mother Grandmother Mother Grandmother Mother Daughter Mother Mother Mother Mother Mother Mother Mother Daughter Mother Mother Mother Daughter Mother Mother Daughter Mother Date: Patient Review: Date: Patient Review: Date: Patient Review: Date: Patient Review: MD Review:  |                       |               |                  | H             |        |                            |               |  |
| Hives Pancreatic Cancer Melanoma Lymphoma Leukemia Other Cancers (Please list breast and ovarian history below)  Have you ever been tested for BRCA1/BRCA2 Mutations?   NO   |                       |               |                  | H             |        | type:                      |               |  |
| Pancreatic Cancer Melanoma Lymphoma Leukemia Other Cancers (Please list breast and ovarian history below)  Have you ever been tested for BRCA1/BRCA2 Mutations?   NO   |                       |               | H                |               |        | ιγρε                       |               |  |
| Melanoma Lymphoma Leukemia Other Cancers (Please list breast and ovarian history below)  Have you ever been tested for BRCA1/BRCA2 Mutations?    NO  |                       |               |                  |               |        |                            |               |  |
| Lymphoma Leukemia Other Cancers (Please list breast and ovarian history below)  Have you ever been tested for BRCA1/BRCA2 Mutations?   NO  |                       | ancer         |                  | H             |        |                            |               |  |
| Leukemia Other Cancers (Please list breast and ovarian history below)  Have you ever been tested for BRCA1/BRCA2 Mutations?    NO  |                       |               | 님                | H             | H      | 4                          |               |  |
| Other Cancers (Please list breast and ovarian history below)  Have you ever been tested for BRCA1/BRCA2 Mutations? NO YES If yes, were the results: Positive Negative Uncertain Variant  Are you of Ashkenazi Jewish Ancestry? NO YES HISTORY OF BREAST CANCER: NO YES Age at diagnosis Self Mother Sister Daughter Brother Father Son Mother or Father's side (PLEASE CIRCLE) Grandmother M F Grandfather Mother Grandfather M F Cousin M F Cousin M F Cousin M F Aunt M F Cousin M F Cousin M F Aunt M F Twe may contact you by email, please list your email address:  rint Name: Date: Date: Patient Review: MD Review: M |                       |               | H                |               | H      |                            |               |  |
| Have you ever been tested for BRCA1/BRCA2 Mutations?   NO   YES   fyes, were the results :   Positive   Negative   Uncertain Variant   |                       |               |                  |               |        |                            |               |  |
| NO YES If yes, were the results: Positive Negative Uncertain Variant  Are you of Ashkenazi Jewish Ancestry? NO YES  HISTORY OF BREAST CANCER: NO YES Age at diagnosed with a second NEW Breast Cancer  Self Mother Sister Daughter Son Niece Father's side (PLASS CIRCLE)  No YES Age at diagnosis  Mother or Father's side (PLASS CIRCLE)  Grandmother M F Daughter Sister Daughter Sister Cousin M F  Cousin M F  We may contact you by email, please list your email address:  rint Name: Date: Patient Review: MD Revi |                       |               | below)           |               |        | type:                      |               |  |
| Age at diagnosis   With a second NEW   Breast Cancer    Self   Mother    Sister   Daughter    Brother   NO YES    Father   Safe   Age at diagnosis    Mother or    Father's side   PLEASE CIRCLE    Grandmother   M F    Grandfather   M F    Uncle   M F    Cousin   M F    Cousin   M F    Cousin   M F    We may contact you by email, please list your email address:  | HISTORY OF B          | REAST CANCER: | Age if diagnosed |               |        |                            |               |  |
| Mother   Sister   Daughter   HISTORY OF OVARIAN CANCER:  Brother   NO YES   Age at diagnosis   Self   Mother or Father's side (PLEASE CIRCLE)   Sister   Daughter   Father's side (PLEASE CIRCLE)   Sister   Date   Date:   Date:  |                       | _             |                  |               |        |                            |               |  |
| Sister  Daughter  Brother  Father  Son  Niece  Nephew  Grandmother  Grandfather  Aunt  Uncle  Cousin  Mother  Mother  Mother  Mother  Mother  Mother  Mother  Mother  Daughter  Sister  Daughter  Sister  Daughter  Father's side  Niece  Grandmother  Mother or  Father's side  Niece  Daughter  Father's side  Niece  Grandmother  Mother or  Father's side  Niece  Date  Father's side  Father's side  Niece  Date  Father's side  Niece  Date  Father's side  Niece  Date  Father's side  Father's side  Niece  Date  Date  Date  Date  Date  Date:  Date:  Date:  Date:  MD Review:   | Self                  |               |                  | 1             |        |                            |               |  |
| Daughter Brother Broth |                       |               |                  | 1             |        |                            |               |  |
| Brother  |                       |               |                  |               |        |                            |               |  |
| Father Son   |                       |               |                  |               |        | HISTORY OF OVARIAI         | N CANCER:     |  |
| Son   Mother or Father's side (PLEASE CIRCLE)   Sister   Mother or Father's side (PLEASE CIRCLE)   Sister   Daughter   Father's side (PLEASE CIRCLE)    Grandmother   M F   Daughter   Mother or Father's side (PLEASE CIRCLE)    Niece   Niece   Mother or Father's side (PLEASE CIRCLE)    Orandfather   M F   Niece   Grandmother   M F    Cousin   M F   Cousin   M F    Twe may contact you by email, please list your email address:  Trint Name:  |                       |               |                  |               |        | NO YES                     |               |  |
| Niece   Father's side (PLEASE CIRCLE)   Sister   Daughter or Father's side (PLEASE CIRCLE)   Sister   Daughter or Father's side (PLEASE CIRCLE)   Sister   Daughter or Father's side (PLEASE CIRCLE)   Niece   Patient Review: Date:   |                       |               |                  | 1             |        | Age at c                   | liagnosis     |  |
| Niece   Father's side (PLEASE CIRCLE)   Sister   Daughter or Father's side (PLEASE CIRCLE)    Grandmother   M F   Daughter   Niece   Patient Review:   Mother or Father's side (PLEASE CIRCLE)    Niece   Grandmother   M F    Cousin   M F    Aunt   M F    Date: Date:    Date:   Date:    Patient Review:   Date:    FFICE USE   MD Review:   MD Review:   MD Review:    Mother or Father's side (PLEASE CIRCLE)    Nother or Father's side (PLEASE CIRCLE)    Nothe |                       |               |                  | Mother or     |        | Self                       |               |  |
| Grandmother  |                       |               |                  | Father's side |        | Mother                     |               |  |
| Grandfather  |                       |               |                  | 1             | $\neg$ | Sister                     |               |  |
| Grandfather   M F   Niece   (PLEASE CIRCLE)  Aunt   M F   Grandmother   M F    Uncle   M F   Cousin   M F    We may contact you by email, please list your email address:  In this way is a series of  |                       |               |                  | 1             | _      | Daughter                   |               |  |
| Uncle  | Grandfather           |               |                  | 1             |        | Niece                      |               |  |
| Cousin   |                       |               |                  | M F           |        | Grandmother                | M F           |  |
| we may contact you by email, please list your email address:  rint Name:   |                       |               |                  | M F           |        | Cousin                     | M F           |  |
| rint Name: Date of birth: Date:  | Cousin                |               |                  | M F           |        | Aunt                       | M F           |  |
| ignature: Date:  | •                     |               | •                |               |        | '                          |               |  |
| atient Review: Date: Patient Review: Date:   | Print Name:           |               |                  |               |        | Date of birth:             | Date:         |  |
| atient Review: Date: Patient Review: Date:   | ignature:             |               |                  |               |        | Date:                      |               |  |
|  |                       |               |                  |               |        |                            |               |  |
|  | FFICE USE \(\Lambda\) | AD Review:    |                  | MD Review:    |        | MD Reviev                  | v:            |  |