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.*

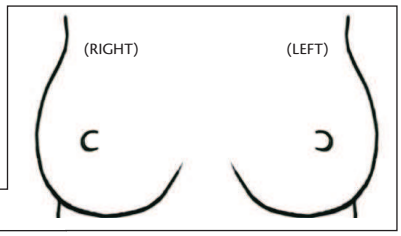
EWBC MEDICAL HISTORY FORM M.R.#_____

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

1. Purpose of today's visit? _____
2. Do you use:
   a. Hormones? Yes No Brand _____ Dosage _____ How long? _____ If discontinued when? _____
   b. Oral Contraceptive? Yes No Brand _____
   c. Anti-Estrogen/Breast Cancer Prevention? Yes No Brand _____
3. Do you have breast implants? Yes No *(type)* Silicone Gel Saline Combination Unknown
4. Are you taking aspirin or blood thinners? Yes No
5. Are you allergic to any of the following?
   a. Medicine(s)? Yes No *(type)* _____
   b. Adhesive Tape? Yes No
   c. Lidocaine? Yes No
   d. Iodine Contrast Material? Yes No
   e. Latex? Yes No
   f. Others? _____
6. Do you currently have any of the following? – *please check only those that apply to you and explain below:*
   ☐ Fever/Chills ☐ Weakness ☐ Leg Swelling ☐ Seasonal Allergies
   ☐ Eye Problems ☐ Depression ☐ Joint Aches ☐ Stomach Problems
   ☐ Kidney Problems Explanation _____

OFFICE USE ONLY ☐ All other systems negative

7. Questions for female patients: *(please circle your answers)*
   1. How many months since your physician examined your breasts? _____ months
   2. Your age at birth of your 1st child.____ No biological children ☐
   3. Your age at time of 1st menstrual cycle. ____
      a. Are your periods regular? Yes No *if no, date of your last period* _____
   4. Age you entered menopause. ____ (If you are no longer having periods for at least one year).
   5. Are you pregnant? Yes No
   6. Are you breastfeeding? Yes No
   7. Do you have your ovaries? Yes No
   8. Do you have your uterus? Yes No
   9. Have you had breast surgery? Yes No



If yes, please mark the area of surgery with the year it was done.

   10. Have you ever had radiation therapy to your breast/chest area? ☐ Yes ☐ No
       if yes, when? _____
   11. Have you ever had chemotherapy? ☐ Yes ☐ No if yes, when? _____
       for what? _____

8. Social History: ☐ Male ☐ Female
   Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Partner ☐ Widowed
   Occupation: _____
   Do you drink alcohol? ☐ Yes ☐ No
   if yes, how often? _____

Do you smoke? check one: ☐ Daily ☐ Occasional ☐ Never Smoked ☐ Former Smoker ☐ Unknown

Race: ☐ American Indian ☐ Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Pacific Islander ☐ White

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Preferred Language: ☐ English ☐ Other _____

Please list medications *(include non-prescriptio nedications and birth control pills, write "none" if no n dications are used)*

_____ _____ _____
_____ _____ _____
_____ _____ _____

(over)

9. Medical/Family History: Directions-Check "None" if neither you nor anyone in your family has had this problem. Check "Self" if this is true for you. Check "Family" if a member of your family has had this problem.

	NONE	SELF	FAMILY	
Breast Cysts	☐	☐		
Breast Pain	☐	☐		
Nipple Changes				
Inversion: ☐ Left ☐ Right				
Discharge: ☐ Left ☐ Right				
Rash: ☐ Left ☐ Right				
HIV	☐	☐		
Heart Valve Replacement	☐	☐		
High Blood Pressure	☐	☐		
Pacemaker/Cardiac Stent	☐	☐		
Heart Attack	☐	☐		
Stroke	☐	☐		
Hepatitis/Liver Problems	☐	☐		*type:* _____
Asthma	☐	☐		
Diabetes	☐	☐	☐	
Arthritis	☐	☐	☐	*type:* _____
Hives	☐	☐	☐	
Pancreatic Cancer	☐	☐	☐	
Melanoma	☐	☐	☐	
Lymphoma	☐	☐	☐	*type:* _____
Leukemia	☐	☐	☐	*type:* _____
Other Cancers *(Please list breast and ovarian history below)*	☐	☐	☐	*type:* _____

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	Age if diagnosed with a second NEW Breast Cancer	Mother *or* Father's side (PLEASE CIRCLE)
Self			
Mother			
Sister			
Daughter			
Brother			
Father			
Son			
Niece			
Nephew			
Grandmother			M F
Grandfather			M F
Aunt			M F
Uncle			M F
Cousin			M F

HISTORY OF OVARIAN CANCER:

☐ NO ☐ YES

	Age at diagnosis	Mother *or* Father's side (PLEASE CIRCLE)
Self		
Mother		
Sister		
Daughter		
Niece		
Grandmother		M F
Cousin		M F
Aunt		M F

If we may contact you by email, please list your email address: _____

Print Name: _____ Date of birth: _____ Date: _____

Signature: _____ Date: _____

Patient Review: _____ Date: _____ Patient Review: _____ Date: _____

OFFICE USE ONLY	MD Review: _____ Date: _____	MD Review: _____ Date: _____	MD Review: _____ Date: _____

The above information is accurate and any unanswered questions are considered not applicable or negative.