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General and Vascular Surgery

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Breast Evaluation:

Any history of breast cancer in your family? ______________________________

Have you ever had breast surgery? ______________________________

If so, which breast? ______________ For what reason? ______________________________

Do you have breast implants? ______________________________

Any history of breast trauma? ______________________________

Any history of nipple discharge? ______________________________

At what age did you start menstruating? ______________________________

If applicable, at what age did you start menopause? ______________________________

Number of pregnancies? ______________ Dates: ______________________________

Did you breast feed? ______________ Dates: ______________________________

Any history of hormonal medication use,
e.g. birth control pills, Premarin or thyroid medications? ______________________________

Dates: ______________________________

Any history of chest radiation treatment or excessive x-ray therapy? ______________________________

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Do you honestly do monthly breast self-examinations? ______________________________

List any major medical problems: ______________________________

List any past surgeries: ______________________________

Do you smoke? ______________ How much? ______________________________

Do you consume alcohol? ______________ How often? ______________________________

Medications: ______________________________

Allergies: ______________________________