**PATIENT HISTORY SHEET**

**MAMMOGRAM HISTORY**
- First Mammogram: Y/N
- Date of last Mammogram: ____________________________
- Location of prior Mammogram: ____________________________

**ANY POSSIBILITY OF PREGNANCY?**
- Yes □ No □
- Date of Last Menstrual Cycle: ____________________________

**PATIENT BREAST COMPLAINT/REASON FOR EXAM**
- □ None
- □ Lump: Right □ Left □ Axilla □ Duration: ________
- □ Nipple Discharge: Right □ Left □ Duration: ________
- □ Other Breast Specific Concern: ____________________________

**FAMILY HISTORY OF BREAST CANCER**
- Age at Diagnosis of Breast Cancer in:
  - □ None
  - □ Mother: ________
  - □ Sister(s): ________
  - □ Aunt(s): ________

**PATIENT HISTORY (Check all that apply)**
- □ Breast Cancer Gene: ____________________________
- □ Previous Chest Radiation Therapy: Date: ________
- □ Ovarian Cancer
- □ Previous Breast High Risk Lesion
  - □ ADH (Atypical Hyperplasia)
  - □ LCIS
- □ Other Cancer Diagnosis: ____________________________

**BREAST CANCER HISTORY (Check all that apply)**
- □ Mastectomy: Right □ Left □ Date: ________
- □ Lumpectomy: Right □ Left □ Date: ________
- □ Radiation Therapy: Right □ Left □ Date: ________
- □ Reconstruction: Right □ Left □ Date: ________

**BENIGN BREAST SURGERY / BIOPSY HISTORY**
- (Check all that apply)
  - □ Surgical Biopsy: Right □ Left □ Date: ________
  - □ Reduction: Right □ Left □ Date: ________
  - □ Breast Lift: Right □ Left □ Date: ________
  - □ Implants: Right □ Left □ Date: ________
  - □ Implant Removal: Right □ Left □ Date: ________

**Do not write in this box**

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**Houston Methodist Breast Care Center**

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Breast Center