WOMEN'S COLLEGE HOSPITAL
Health care for women | REVOLUTIONIZED
76 Grenville Street, Toronto, ON M5S 1B2

HENRIETTA BANTING BREAST CENTRE HISTORY FORM

PATIENT IDENTIFICATION

Date: _____/___/___
YYYY/MM/DD

Breast Centre Physician_____

Health Card Number_____

Name (Mr./Miss/Mrs./Ms.)_____
Last First

Date of birth: _____/___/___ Present Age_____years
YYYY/MM/DD

Address: _____
and street, unit # town/city postal code

Telephone number: _____ _____ _____
Home cellular business

May we leave a phone message concerning appointment or appointment changes at these numbers? ❑ Yes ❑ No

Email address_____ May we use e-mail to contact you? ❑ Yes ❑ No

First Language: ❑ English Other_____

Marital Status_____ Occupation _____

Ethnic Background (for the purpose of cancer risk assessment)_____

Referring Doctor Information

Dr_____ Phone number_____

Address_____

Name of additional physicians to send correspondence (if any)_____

_____

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BREAST HISTORY

Describe in your own words, the main problem you are presently having with your breast(s):

_____

_____

Do you have any of the following breast problems? (Tick ✓ all that apply)

	Left Breast	Right Breast	Both breasts
Lump			
Pain or tenderness			
Swelling			
Redness			
Changes in Nipple			
Nipple Discharge			
Abnormal Mammogram, Ultrasound or MRI			

Have you had a recent:

Mammogram Date: _____/___/_____ (YYYY/MM/DD) Where _____

Breast Ultrasound Date: _____/___/_____ (YYYY/MM/DD) Where _____

Breast MRI Date: _____/___/_____ (YYYY/MM/DD) Where _____

Breast Biopsy Date: _____/___/_____ (YYYY/MM/DD) Where_____

Did you bring copies of imaging films or discs, done at other centres, with you to this appointment? ❑ Yes ❑ No

Have you ever had problems with your breasts in the past? ❑ Yes ❑ No If yes, Describe_____

_____

Have you been diagnosed with Breast Cancer? ❑ Yes ❑ No If yes, please list treatments: _____

_____

Surgery: ❑ Yes ❑ No If yes, type? _____

Chemotherapy: ❑ Yes ❑ No If yes, where? _____ When completed? Date: _____/___/_____ (YYYY/MM/DD)

Radiation Therapy: ❑ Yes ❑ No If yes, where? _____ When completed? Date: _____/___/_____ (YYYY/MM/DD)

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LYMPHEDEMA (arm swelling)

Do you have lymphedema? ❑ Yes ❑ No

If yes, what sort of treatments have you had?_____

Have you been told you are at high risk for lymphedema? ❑ Yes ❑ No

MENSTRUAL HISTORY

How old were you when your first period started? _____ years

What was the date your last period began? Date: _____/___/___
YYYY/MM/DD

Have you ever used any type of hormonal birth control (pills, patch, injection, ring) ❑ Yes ❑ No

If yes, Name_____ For how long? _____

How old were you when you started menopause (if applicable) _____

Did your periods stop naturally? ❑ Yes ❑ No

If no, did you have a hysterectomy? ❑ Yes ❑ No Your age at time of surgery? _____

Ovaries removed? ❑ Yes ❑ No If yes, 1 or 2?____

Are you currently on Hormone Replacement Therapy or have you taken hormone replacement in the past? ❑ Yes ❑ No

If yes, please indicate: name: _____ When did you start taking it?_____ When did you stop?_____

PREGNANCIES

Are you currently pregnant? ❑ Yes ❑ No Are you currently breast feeding? ❑ Yes ❑ No

Have you ever been pregnant? ❑ Yes ❑ No

Please list all pregnancies below (include miscarriages and abortions)

Your age at the time of pregnancy	Sex of fetus	Length of Pregnancy	Months breast fed

Did you have any problems with breast feeding? ❑ Yes ❑ No If yes, describe_____

_____

_____

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GENERAL HISTORY

List any major medical problems you have such as heart problems or diabetes: _____

_____

_____

List all previous surgeries and the year or age at which they were performed: _____

_____

_____

Do you have any drug allergies? ❑ Yes ❑ No If "yes", please list what you are allergic to **and** the reaction you have:

_____

_____

Please list all the medications, over the counter drugs and herbal supplements you are currently taking:

Type	Dosage	Frequency	Type	Dosage	Frequency
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Your current: Height_____ Weight_____

ADDITIONAL HEALTH INFORMATION

Do you smoke? ❑ Yes ❑ No How much and how long?_____

Have you smoked in the past? ❑ Yes ❑ No If yes, when did you quit? _____/_____
Year / Month

Do you drink alcohol? ❑ Yes ❑ No

If yes, how many drinks per day or per week? _____

Do you drink beverages with caffeine (e.g. coffee, pop) ❑ Yes ❑ No If yes, how often? _____

Do you eat more than 5 servings of fruit and vegetables per day? ❑ Yes ❑ No

What type of exercise do you do and how often? (e.g. walking aerobic, running): _____

_____

_____

Print Name: _____Signature: _____ Designation: _____

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FAMILY HISTORY

Please list below your family history of breast cancer, or any other cancers

Type of Cancer	Relation (mother, sister, aunt and if maternal/paternal)	Age Diagnosed	Present age (or age at death)	Any Recurrence after treatment?

Signature_____ Date: _____/___/____
YYYY/MM/DD

PEDIGREE (for physician use only)

Physician Name: Print: _____ Signature: _____ Date: _____/___/____
YYYY/MM/DD