PRINCETON SURGICAL ASSOCIATES

Date: ______________________________

Name: ____________________________ Age: _____ Referring Doctor: _______________________

Menstrual History: Age at Onset: ________ Age Ended: __________ Last Period: ___________

Are symptoms related to menstrual Cycle? No________ Yes__________

Hormones: (Name & Duration) Birth Control Pills: _____________Other Hormones _____________

Childbirth History: Number of Pregnancies ________ Number of Children ________

Age at birth of first child _________ Did you Nurse? _________ How Long? _________

Family History: Has any maternal or paternal relative had breast cancer? No____ Yes ______

Mother _____ Sister _____ Daughter _____ Grandmother _____ Aunt _____ Cousin _____

Ovarian Cancer___________ Uterine Cancer _____________ Colon Cancer ________________

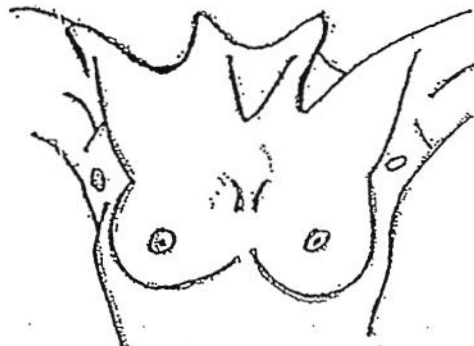
Have you had a Mammography? No ____ Yes ____ When? _____ Where? ______________

Symptoms	Right	Left	Duration of Symptoms
Palpable Lump(s)			
Pain			
Nipple Discharge			
Dimpling/Discoloration			
Abnormal Mammogram			
Second Opinion			
Breast History	**Right**	**Left**	**Date**
Aspirations			
Biopsy			
Lumpectomy, axillary dissection			
Mastectomy			
Radiation Therapy			
Chemotherapy			

For Doctor Use Only

RT	MASS	LT
______	NONE	______
______	SINGLE	______
______	MULT	______
______	HARD	______
______	SOFT	______
______	CYSTIC	______
______	MOVABLE	______
______	FIXED SKIN	______
______	FIXED DEEP	______
______	REGULAR	______
______	IRREGULAR	______

SIZE: ____________________



Comments: ____

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____MD