

# Breast Care Center of Florida

Kamy Kemp, M.D.

ID#: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_

**CURRENT BREAST PROBLEMS**

- Lump  Right  Left
- Pain  Right  Left
- Nipple Discharge  Right  Left
- Bloody
- Serous
- Tenderness  Right  Left
- Other Please describe: \_\_\_\_\_

**DID YOU BRING PREVIOUS MAMMOGRAMS TODAY?**

- Yes  No

**IMPLANTS**  NONE

- Saline  Right  Left  Pre-pectoral  Post-pectoral
- Silicone Gel  Right  Left  Pre-pectoral  Post-pectoral

**REPRODUCTIVE HISTORY**

Date (or Age) \_\_\_\_\_

Have you had a Hysterectomy?  Yes  No \_\_\_\_\_

Were your ovaries removed?  Left  Right  No \_\_\_\_\_

**PERSONAL HISTORY**

Are you pregnant?  Yes  No Age at First Period: \_\_\_\_\_ Number of Pregnancies: \_\_\_\_\_

Date of last menstrual period: \_\_\_\_\_ Age at Menopause: \_\_\_\_\_ Number of Births: \_\_\_\_\_

Age at First Pregnancy: \_\_\_\_\_

**BREAST SURGERY**

- |   |                               |                                     |                                |                                     |
|---|-------------------------------|-------------------------------------|--------------------------------|-------------------------------------|
| <input type="checkbox"/> Core Biopsy            | <input type="checkbox"/> Left | <input type="checkbox"/> Date _____ | <input type="checkbox"/> Right | <input type="checkbox"/> Date _____ |
| <input type="checkbox"/> Fine Needle Aspiration | <input type="checkbox"/> Left | <input type="checkbox"/> Date _____ | <input type="checkbox"/> Right | <input type="checkbox"/> Date _____ |
| <input type="checkbox"/> Lumpectomy (cancer)    | <input type="checkbox"/> Left | <input type="checkbox"/> Date _____ | <input type="checkbox"/> Right | <input type="checkbox"/> Date _____ |
| <input type="checkbox"/> Lumpectomy w/radiation | <input type="checkbox"/> Left | <input type="checkbox"/> Date _____ | <input type="checkbox"/> Right | <input type="checkbox"/> Date _____ |
| <input type="checkbox"/> Mastectomy             | <input type="checkbox"/> Left | <input type="checkbox"/> Date _____ | <input type="checkbox"/> Right | <input type="checkbox"/> Date _____ |
| <input type="checkbox"/> Reconstruction         | <input type="checkbox"/> Left | <input type="checkbox"/> Date _____ | <input type="checkbox"/> Right | <input type="checkbox"/> Date _____ |
| <input type="checkbox"/> Reduction              | <input type="checkbox"/> Left | <input type="checkbox"/> Date _____ | <input type="checkbox"/> Right | <input type="checkbox"/> Date _____ |

**RISK FACTORS**

Have you had any kind of cancer?  Yes  No If yes, specify: \_\_\_\_\_

Family history of breast cancer?

<input type="checkbox"/> Mother	Age at diagnosis _____	<input type="checkbox"/> Post Menopausal
<input type="checkbox"/> Grandmother	Age at diagnosis _____	<input type="checkbox"/> Post Menopausal
<input type="checkbox"/> Sister	Age at diagnosis _____	<input type="checkbox"/> Post Menopausal
<input type="checkbox"/> Daughter	Age at diagnosis _____	<input type="checkbox"/> Post Menopausal
<input type="checkbox"/> Other	Age at diagnosis _____	<input type="checkbox"/> Post Menopausal

Family History of Other Cancer?

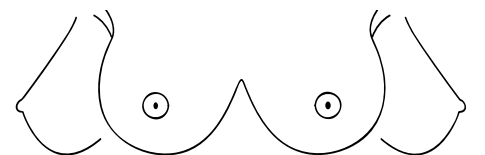
<input type="checkbox"/> Ovarian	Relative(s) _____	Age at diagnosis _____
<input type="checkbox"/> Colon	Relative(s) _____	Age at diagnosis _____
<input type="checkbox"/> Lymphoma	Relative(s) _____	Age at diagnosis _____
<input type="checkbox"/> Melanoma	Relative(s) _____	Age at diagnosis _____
<input type="checkbox"/> Pancreas	Relative(s) _____	Age at diagnosis _____
<input type="checkbox"/> Endometrial	Relative(s) _____	Age at diagnosis _____
<input type="checkbox"/> Other	Please Describe: _____	

**HORMONES/CONTRACEPTIVES**

Type: _____	Type: _____	Type: _____
Currently Using? <input type="checkbox"/> Yes <input type="checkbox"/> No	Currently Using? <input type="checkbox"/> Yes <input type="checkbox"/> No	Currently Using? <input type="checkbox"/> Yes <input type="checkbox"/> No
1st Use (Date or Age): _____	1st Use (Date or Age): _____	1st Use (Date or Age): _____
Last Use (Date or Age): _____	Last Use (Date or Age): _____	Last Use (Date or Age): _____

**THERAPY**

- Chemotherapy  Yes  No Dates \_\_\_\_\_
- Radiation therapy  Yes  No Dates \_\_\_\_\_
- Hormonal treatment of cancer  Yes  No Dates \_\_\_\_\_
- Radiation and chemotherapy  Yes  No Dates \_\_\_\_\_
- Radiation and hormonal therapy  Yes  No Dates \_\_\_\_\_



Please indicate any scars you may have on your breasts