INITIAL CONSULTATION INFORMATION
(to be completed by all female breast patients)

NAME:_____
_____

PART A: Breast risk assessment

Do you have a history of breast disease or breast operations? **Yes** ☐ **No** ☐
If yes, please list type and year.

_____

_____

Do you have a family history of breast cancer? **Yes** ☐ **No** ☐
If yes, please provide details (relative, mother's or father's side, age at diagnosis).

_____

_____

Do you have a family history of other cancers? **Yes** ☐ **No** ☐
If yes, please provide details (relative, mother's or father's side, age at diagnosis).

_____

_____

Number of previous pregnancies (including miscarriages and/or terminations) _____

Number of full-term pregnancies _____

Age at first pregnancy (if applicable) _____

Number of children breastfed and for how long _____

Have you had infertility treatment in the past? (eg IVF or Clomid) **Yes** ☐ **No** ☐

Age first period commenced _____

Have you been through menopause? **Yes** ☐ **No** ☐ **Not sure** ☐

Age menopause commenced (if relevant) _____

Have you had a hysterectomy? **Yes** ☐ **No** ☐

If yes, were the ovaries removed at the same time? **Yes** ☐ **No** ☐

Are you currently taking the oral contraceptive pill? **Yes** ☐ **No** ☐

If no, have you taken the oral contraceptive pill in the past? **Yes** ☐ **No** ☐

If yes, for how long and when did you stop? _____

Are you currently taking hormone replacement therapy (including 'natural' or 'bio-identical' products)? **Yes** ☐ **No** ☐

If no, have you taken hormone replacement therapy in the past? **Yes** ☐ **No** ☐

If yes, for how long and when did you stop? _____

Have you had previous radiotherapy? **Yes** ☐ **No** ☐

Do you smoke? **Yes** ☐ **No** ☐

If yes, how many cigarettes per day? _____

Do you drink alcohol? **Yes** ☐ **No** ☐

If yes, how many standard drinks per day? _____

Please see over

NAME:_____
_____

PART B: General information

Occupation _____

Relationship status (single, married, de facto, divorced) _____

Who lives with you at home? (include partner's name if applicable)_____

_____

What is your ethnic background? _____

Do you have any Ashkenazi Jewish ancestry? **Yes** ☐ **No** ☐

Do you have any allergies? **Yes** ☐ **No** ☐

If yes, please list them _____

_____

Do you have diabetes? **Yes** ☐ **No** ☐

Are you asthmatic? **Yes** ☐ **No** ☐

Are you on Aspirin/Warfarin/blood thinners? **Yes** ☐ **No** ☐

What other health issues do you have? _____

_____

_____

What medications are you currently taking? _____

_____

_____

Are you taking any complementary or alternative medicines? **Yes** ☐ **No** ☐
(such as herbal remedies or high doses of vitamins)

If yes, which ones? _____

_____

Height _____

Weight_____