

## **BREAST CARE**

			CEITE	R INTAKE FORM		
ame:			7	Foday's Date:		
ate of Birth:			1			
ate of Birtin:			1	Referring Provider:		
New diagnosi		<b>□</b> B	Breast Lump	☐ Family history of breast☐ Nipple Problem		er —
ate:	ecent breast imaging?	(Mamm	nogram, ultras	ound, MRI):		
	ny of the prior breast  ☐ Mastectomy ☐ Ne			st Reduction 🗖 Breast Augme	entatio	on
Other:						
Diabetes High Cholest				of blood thinners (ex. aspirin, ker/E-cigarettes	,	
Synecologic Hi		v	H/F	•		10
Age of first per	iod		IVF:		ES / N	
Age of first per Age of first chil	iod !dbirth	*1	Birth control >	5 years: Y	ES/N	10
Age of first per Age of first chil	iod	*1	Birth control >		ES/N	10
Age of first per Age of first chil Age at menopa amily History reast Cancer: varian Cancer	iod  dbirth use	*H *H er/father	Birth control > Iormone replace r/siblings)	5 years: YE cement therapy > 5 years: YE	ES / N ES / N cle/gra	NO NO andpa
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Date:\_\_\_\_\_

Date:\_\_\_\_\_

Patient Signature:

Physician Signature: