

Colorado Surgical Service – Breast History & Physical

Name: _____ DOB: _____ Date: _____

Referring Physician: _____

Primary Care: _____

HPI: _____

PMH: _____

PSHx: _____

Meds: _____

Allergies: _____

Family Hx of Breast/Ovarian CA: _____

Family Hx: _____

Signed: _____

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History of Hormones: _____

Age of 1st Menses: _____ LMP/Menopause: _____ Bra Size: _____

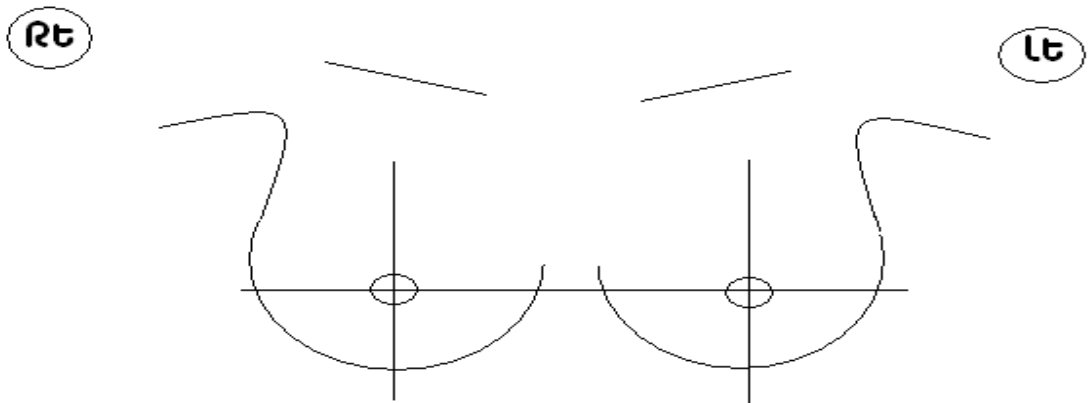
Age of 1st pregnancy: _____ G: _____ P: _____ Breast feeding: _____

Occupation: _____ Tobacco: _____ ETOH: _____

Caffeine Intake: _____ Religious Background: _____

ROS: _____

Physical Exam: VSS: _____



Imaging: _____

Plan: _____

Signed: _____