

**BARBER & RICHARDSON, PC.**  
**WILLIAM A. BARBER, M.D., F.A.C.S.**  
**HEATHER RICHARDSON, M.D., F.A.C.S.**  
**AMANDA J. MOREHOUSE, M.D.**

**NEW BREAST PATIENT**

Name \_\_\_\_\_ Today's Date \_\_\_\_\_ Age \_\_\_\_\_

Occupation \_\_\_\_\_

Reason for visit \_\_\_\_\_ Date of last period \_\_\_\_\_

Age at time of first period \_\_\_\_\_ Age at delivery of 1<sup>st</sup> child \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

If you have or have had any of the following please check and describe:

	<b>Yes</b>	<b>No</b>	<b>Comments</b>
Nipple discharge	( )	( )	_____
Pain in breasts	( )	( )	_____
Estrogen/Birth Control Pills	( )	( )	_____
Fertility Medications	( )	( )	_____
Pregnancies	( )	( )	_____
Did you breast feed?	( )	( )	_____
Family History of Breast Cancer	( )	( )	_____
Family History of Other Cancers	( )	( )	_____

**WHEN    WHERE    RESULTS**

Recent Mammogram	( )	( )	_____
Breast ultrasound	( )	( )	_____
Breast Biopsy or Surgery	( )	( )	_____

Caffeine drinks daily \_\_\_\_\_ Alcohol: Daily \_\_\_\_\_ Weekly \_\_\_\_\_ Rarely \_\_\_\_\_ None \_\_\_\_\_