Dr. Kovacev Breast Cancer Screening and Risk Analysis Pathway

Name: _____ Age :_____
Birthday: _____ Date : _____
Height: _____ Weight: _____ Breast Size: _____

Have You Experienced Any of the Following in the Last 3-6 Months?	Yes	No	Unsure
Breast Pain			
Breast Lump / Mass			
Nipple Discharge			
Skin Retraction or Nipple Skin Changes			
Breast Redness or Swelling			
Breast Rash, Itching, Scaling of Skin			
Breast Augmentation			
Change in Breast Size, Shape, Symmetry			
Can You Express Fluid From Nipples			
Lump in Neck, Collarbone Area			
Lump in Armpit			
Weight Loss			
Menstrual Irregularities			
Gynecologic Problems			
Change in Bowel or Bladder Habits			

Have You Had Any of the Following:

Clinical Breast Exam by Physician: ☐Yes ☐No Date:

Mammograms / Ultrasound / MRI: ☐Yes ☐No Dates:
_____

Results: _____

Number of Breast Biopsies: _____ Type (circle) : FNA / Core / Surgery

Results: _____

Age Menstruation Began: _____ Menopause Age: _____
(no menstruation for 12 months)

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Have You Used Hormone Replacement (HRT) : ☐Yes ☐No

Age at First HRT use: _____ Age of Last Use _____ # Years Used: _____

How Many Children Do You Have: _____

How Old Were YOU When Your 1st Child Was Born: _____

How Many Alcoholic Drinks Do You Have Per Day: _____ Type: _____

Have You Ever Had Radiation to the Breast or Chest ☐Yes ☐No

Do You Have a Known Genetic Cancer Mutation ? ☐Yes ☐No

If So Which: ☐BRCA I ☐BRCA II ☐PTEN ☐CHD1 ☐P53 ☐STK11

What is your Race: ☐Caucasian ☐Hispanic ☐African American ☐Asian

Other: _____

Please Place a Check For the Family Members Whom Have a Confirmed Diagnosis of Breast Cancer:

Family	Yes	No	Unsure	Age @ diagnosis
Father				
Mother				
Paternal Grandmother				
Maternal Grandmother				
Maternal Aunt				
Maternal Aunt 2				
Maternal Aunt 3				
Sister				
Sister				
Sister				
Other				

Is there any other items you wish to discuss with Dr. Kovacev?

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