

Today's date ____ / ____ / ____ Birth date ____ / ____ / ____
month day year last 4 digits of SS#

Name _____ Age _____

Referring MD _____ 2nd MD to get report _____

Last mammogram: NEVER **or** Year _____ Where? _____

Last breast MRI: NEVER **or** Year _____ Breast-Specific Gamma Imaging: NEVER **or** Year _____

When was your last breast physical exam by your physician? _____

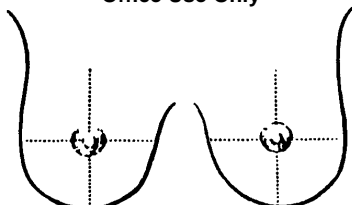
More than 10 lb. weight change since last mammogram: Lost ____ lbs. Gained ____ lbs.

Age when you began menstrual periods _____ Age when you had your 1st baby _____

Yes	No	Do you CURRENTLY:	Which breast?	How long?
<input type="checkbox"/>	<input type="checkbox"/>	Examine your breasts regularly		
<input type="checkbox"/>	<input type="checkbox"/>	Have a breast lump felt by you or your doctor	left right	_____
<input type="checkbox"/>	<input type="checkbox"/>	Have new thickening in your breast	left right	_____
<input type="checkbox"/>	<input type="checkbox"/>	Have new breast pain or tenderness	left right	_____
<input type="checkbox"/>	<input type="checkbox"/>	Have an inverted nipple	left right	_____
<input type="checkbox"/>	<input type="checkbox"/>	Have nipple discharge or bleeding	left right	_____
<input type="checkbox"/>	<input type="checkbox"/>	Use hormones or birth control pills - Type _____		_____
<input type="checkbox"/>	<input type="checkbox"/>	Have any chance of pregnancy * <u>If NO</u> , sign here _____		
		<input type="checkbox"/> 1 st day of last menstrual period ____ / ____ / ____		<input type="checkbox"/> Menopause at age _____
		<input type="checkbox"/> Hysterectomy at age _____		<input type="checkbox"/> Ovaries removed at age _____
<input type="checkbox"/>	<input type="checkbox"/>	Have any breast concerns: _____		

Yes	No	Do you have any history of:
<input type="checkbox"/>	<input type="checkbox"/>	Non-breast cancer – Type _____ year: _____
<input type="checkbox"/>	<input type="checkbox"/>	Relative with breast cancer <input type="checkbox"/> Mother (age diagnosed ____)
		<input type="checkbox"/> Daughter
		<input type="checkbox"/> Sister (age diagnosed ____)
		<input type="checkbox"/> Other _____
<input type="checkbox"/>	<input type="checkbox"/>	Testing for breast cancer <u>gene</u> in you or your family. Details: _____
<input type="checkbox"/>	<input type="checkbox"/>	Ashkenazi Jewish heritage <input type="checkbox"/> unknown
<input type="checkbox"/>	<input type="checkbox"/>	Cyst aspiration, needle biopsy, or surgery of the <u>breast</u> (<i>Check all that apply</i>)
		<input type="checkbox"/> Aspiration (drainage) of breast cysts
		<input type="checkbox"/> Benign needle biopsy (not cyst aspiration) <u>How many?</u> left ____ right ____
		<input type="checkbox"/> Surgical biopsy w/benign results (not cancer) <u>How many?</u> left ____ right ____
		<input type="checkbox"/> Atypical hyperplasia (<input type="checkbox"/> ductal <input type="checkbox"/> lobular) left right year: _____
		<input type="checkbox"/> LCIS (lobular carcinoma in situ) left right year: _____
		<input type="checkbox"/> Breast cancer (<input type="checkbox"/> invasive <input type="checkbox"/> DCIS/intraductal) left right year: _____
		<input type="checkbox"/> mastectomy <input type="checkbox"/> lumpectomy <input type="checkbox"/> radiation <input type="checkbox"/> chemo <input type="checkbox"/> hormonal therapy
		<input type="checkbox"/> Breast implants (<input type="checkbox"/> saline <input type="checkbox"/> silicone <input type="checkbox"/> unsure) year: _____
		<input type="checkbox"/> Breast reduction or breast lift surgery year: _____

Office Use Only



Shield _____
 Room _____
 Cleaned _____
 Tech _____