

Please answer ALL questions below

New Patient Return Patient MRN: _____

Name: _____ Date of Birth: _____ Age: _____

Reason for Exam (Clinical Indications/Signs & Symptoms): _____ Telephone: _____

Are you of Ashkenazi Jewish ancestry? Yes No Race: _____ Ethnicity: _____

Is there a possibility that you may be pregnant? Yes No Have you had your uterus removed? Yes No

Have you nursed in the past 6 months? Yes No Have you had your ovaries removed? Yes No

Are you taking hormones/estrogen? Yes No Are you taking birth control pills? Yes No

If yes, how long? _____ If yes, how long? _____

Are you taking Tamoxifen or other Anti-Estrogen? _____

Date of last breast exam by a doctor or nurse? _____ Age at Menopause: _____

Age at 1st Period: _____ Age at 1st Live Birth: _____ Height: _____ Weight: _____

Have you had a breast biopsy? Yes No Rt. _____ Lt. _____

If yes, when? _____

Benign (FA, FCC, Papilloma) _____ Pre-Cancer (Atypia, LCIS) _____

History of Breast Cancer

Have you had breast cancer? Yes No Rt. _____ Lt. _____

If yes, when? _____ Age at diagnosis: _____

Please circle applicable: DCIS, IDC, ILC

Did you have a Mastectomy? Yes No Rt. _____ Lt. _____

If yes, when? _____

Did you have a lumpectomy? Yes No Rt. _____ Lt. _____

If yes, when? _____

Did you have Chemotherapy? Yes No

If yes, when? _____

Did you receive Radiation Treatment? Yes No

If yes, when? _____

Have you had:

Breast Augmentation – Implants Yes No If yes, when? _____

Breast Reduction: Yes No Breast Lift: Yes No

If yes, when? _____

Have you had ovarian cancer? Yes No Age at Dx: _____

Chest Wall Irradiation for Lymphoma: Yes No

Age at Dx: _____

Is there a family history of breast or ovarian cancer?

If yes, check which apply:

- | | | | |
|--|---------------------------------|----------------------------------|------------|
| <input type="checkbox"/> Mother | <input type="checkbox"/> Breast | <input type="checkbox"/> Ovarian | Age: _____ |
| <input type="checkbox"/> Father | <input type="checkbox"/> Breast | | Age: _____ |
| <input type="checkbox"/> Sister | <input type="checkbox"/> Breast | <input type="checkbox"/> Ovarian | Age: _____ |
| <input type="checkbox"/> Daughter | <input type="checkbox"/> Breast | <input type="checkbox"/> Ovarian | Age: _____ |
| <input type="checkbox"/> Aunt (Mother's Sister) | <input type="checkbox"/> Breast | <input type="checkbox"/> Ovarian | Age: _____ |
| <input type="checkbox"/> Aunt (Father's Sister) | <input type="checkbox"/> Breast | <input type="checkbox"/> Ovarian | Age: _____ |
| <input type="checkbox"/> Grandmother (Mother's Mother) | <input type="checkbox"/> Breast | <input type="checkbox"/> Ovarian | Age: _____ |
| <input type="checkbox"/> Grandmother (Father's Mother) | <input type="checkbox"/> Breast | <input type="checkbox"/> Ovarian | Age: _____ |
| <input type="checkbox"/> First Cousin (Mother's Side) | <input type="checkbox"/> Breast | <input type="checkbox"/> Ovarian | Age: _____ |
| <input type="checkbox"/> First Cousin (Father's Side) | <input type="checkbox"/> Breast | <input type="checkbox"/> Ovarian | Age: _____ |

I understand that this organization provides breast imaging services and that a qualified radiologist interprets the results. Mammography is only one of the recommended actions for early detection of breast cancer. Not all abnormalities are evident on mammography; therefore, a combination of monthly self-exams, annual mammograms and examinations by a physician is the best and most comprehensive program for the detection of breast cancer.

Patient Signature: _____

Have you had genetic testing for BRCA 1 and 2? _____

If yes, did you test positive for either BRCA gene? _____

Has anyone in your family tested positive for the gene(s), and if so, who? _____

Do you have any new symptoms?

Breast Lump

Left: Yes No If yes, how long? _____

Right: Yes No If yes, how long? _____

Pain or Discomfort localized to one area

Left: Yes No If yes, how long? _____

Right: Yes No If yes, how long? _____

Discharge from Nipple

Left: Yes No If yes, how long/color? _____

Right: Yes No If yes, how long/color? _____

Inverted Nipple or Skin Dimpling

Left: Yes No If yes, how long? _____

Right: Yes No If yes, how long? _____

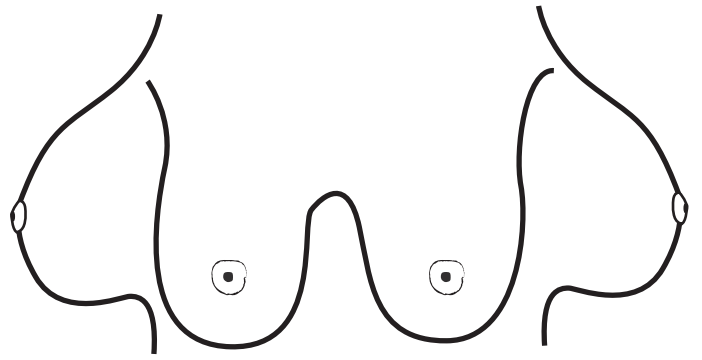
Prior Breast Imaging? If yes, date? Yes No

MAMMO _____ US _____ MRI _____

WHERE: _____

*For Technologist Use Only *

Lifetime Risk: _____ Breast Density _____



Technologist Comments: _____

Technologist Signature: _____