

Patient's Last Name		First/MI	Date of Birth	Age
Home Ph #		Work Ph #		
Patient's Address		City	State	Zip
Referring Doctor			Tech Use MR #	

RISK FACTORS Check if no children Check if late child bearing (first child after 30) Check if breast cancer gene (tested positive for)

Check if you have had any **PERSONAL HISTORY** of cancer: Breast Endometrial (uterus) Ovarian Colon Other: _____

Is there a **FAMILY HISTORY** of breast Cancer? Yes Aunt, grandmother, cousin Before menopause Mother Sister 1 Sister 2 Daughter

GYNECOLOGICAL HISTORY

Age at first period Age at first full-term pregnancy Number of live births

Age at menopause Age at hysterectomy Age ovaries removed R L

IS THERE ANY CHANCE OF PREGNANCY AT THIS TIME? Yes No

BREAST SURGICAL and TREATMENT HISTORY *Please indicate date, type, and result of all breast surgery and treatment*

Implants Right: Silicone Gel Saline Pre-pectoral Retro-pectoral Left: Silicone Gel Saline Pre-pectoral Retro-pectoral

HORMONE HISTORY of:

	Oral Contraceptives	Estrogen	Progesterone	Tamoxifen
Are you currently taking hormones?	Age @ first use			
<input type="checkbox"/> No	Duration of use			
<input type="checkbox"/> Yes		yr mo	yr mo	yr mo
If yes, how long?	Age @ last use			

CURRENT COMPLAINTS/SYMPTOMS Yes No *If YES, please describe:*

Pain and/or soreness Right Left _____

Lump (new or enlarging) Right Left _____

Discharge from nipple Right Left _____

Other: Right Left _____

DATE OF LAST CLINICAL BREAST EXAM PERFORMED BY HEALTHCARE PROVIDER: ____/____/____

Is this your first mammogram?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If NO, how long since your last mammogram?	<input type="checkbox"/> This Facility <input type="checkbox"/> Other:
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The above information is correct. I authorize release of my prior mammograms to this facility

Patient Signature: _____ Date: _____