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Today's Date: _____ Referring Physician: _____

NAME: _____ ID#: _____

Date of birth: _____ Age: _____ Age at first period: _____

Are you pregnant? Yes No Age at first delivery: _____ Number of deliveries: _____

Have you had a hysterectomy? Yes No

Date of last menstrual period: _____ (if applicable) OR Age of menopause: _____

Do you take hormones: Yes No If yes, approximately how long? _____

CURRENT BREAST PROBLEMS

- None OR Lump Right Left Burning Right Left
- Tenderness Right Left Pain Right Left
- Nipple Secretion Right Left Color: _____
- Other Please describe: _____

RISK FACTORS

Have you had any kind of cancer? Yes No If yes, specify: _____

Family history of breast cancer?

- None OR Mother Age at diagnosis: _____
- Sister Age at diagnosis: _____
- Daughter Age at diagnosis: _____
- Other Age at diagnosis: _____

BREAST SURGERY

- None OR Biopsy Left Yr _____ Right Yr _____
- Lumpectomy (cancer) Left Yr _____ Right Yr _____
- Lumpectomy w/radiation Left Yr _____ Right Yr _____
- Mastectomy Left Yr _____ Right Yr _____
- Implants Left Yr _____ Right Yr _____
- Reduction Left Yr _____ Right Yr _____

PREVIOUS MAMMOGRAMS

None OR Date of last mammogram: _____

Where was it done? _____

OFFICE USE ONLY



- Bilat Unl Right Left
- Baseline Follow Up
- Screening Diagnostic
- Sch. for sono CAD

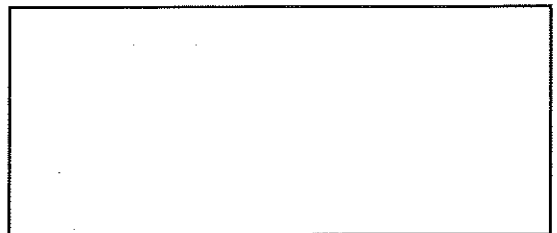
COMMENTS: _____

R.T.(R)(M) _____
TECHNOLOGIST

DO NOT WRITE IN MARGIN



Breast History



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