

First Name _____ Last Name _____ DOB/Age _____

Ht. _____ Wt. _____ Allergies _____ PT# (Internal) _____

REASON FOR EXAM (Please include symptoms and time frame):

TECH NOTES (for internal use only):

Tech Initials:

Additional Tech Notes:

CURRENT SYMPTOMS (circle all that apply)

How Long?

Breast Tenderness/Pain	YES	NO	Right	Left	_____
Lumps	YES	NO	Right	Left	_____
Nipple Discharge	YES	NO	Right	Left	_____
If yes to above, color: _____					
Nipple Retraction	YES	NO	Right	Left	_____
Skin Dimpling	YES	NO	Right	Left	_____

Is this your first mammogram? Yes No If no, When/Where? _____

Have you had a previous Breast ultrasound? Yes No If yes, When/Where? _____

Do you have a history of Prostate Cancer? Yes No If yes, When? _____

Do you have a history of Testicular Cancer? Yes No If yes, When? _____

Do you have a history of smoking? Yes No If yes, Tobacco Marijuana Vapor

Do you have a history of Breast Procedures? Yes No If yes, Describe: _____

Do you have a personal history of Breast Cancer? Yes No If yes, Explain: _____

Do you have a family history of Breast Cancer? Yes No Unknown If yes, Who: _____

History of Hormones or Steroid use? Yes No If yes, Explain: _____

List of Current Medication(s): _____

I agree that the above information is correct (Do not sign until after technologist has reviewed):

Patient Signature: _____ Today's Date: _____