

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ DOB/Age \_\_\_\_\_

Ht. \_\_\_\_\_ Wt. \_\_\_\_\_ Allergies \_\_\_\_\_ PT# (Internal) \_\_\_\_\_

**REASON FOR EXAM:**  Annual Screening  Diagnostic

If Diagnostic, describe symptoms: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**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 \_\_\_\_\_

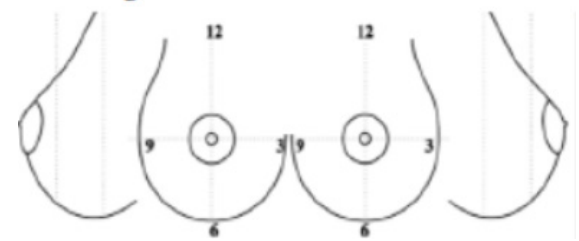
If yes to above, color: \_\_\_\_\_

Nipple Retraction YES NO Right Left \_\_\_\_\_

Skin Dimpling YES NO Right Left \_\_\_\_\_

**TECH ONLY to Complete Diagram**

Right Breast Left Breast



Is this your first mammogram YES NO If no, when/where was your last: \_\_\_\_\_

Have you had a breast ultrasound YES NO When/Where: \_\_\_\_\_

Have you had a hysterectomy YES NO If Yes, Skip next 3 questions.

Are you pregnant YES NO If Yes, MUST inform technologist before exam.

Are you currently breastfeeding YES NO

Are you still having menstrual periods YES NO Date of last cycle: \_\_\_\_\_

Age of first menstrual cycle: \_\_\_\_\_ Age of Menopause: \_\_\_\_\_

Number of Pregnancies: \_\_\_\_\_ Number of Live Births: \_\_\_\_\_ Age of First Pregnancy: \_\_\_\_\_

Are you taking hormones or birth control YES NO Type/How Long: \_\_\_\_\_

Do you have breast implants YES NO Saline Silicone Date Implanted: \_\_\_\_\_

Are you Ashkenazi Jewish inheritance YES NO Are you a smoker? (Circle one) Current Past Never

Have you ever been diagnosed with Breast Cancer? YES NO

What type of breast cancer? \_\_\_\_\_ Location: \_\_\_\_\_

Current status (circle one): Newly Diagnosed Remission Recurrence Date Diagnosed: \_\_\_\_\_

Treatments (circle one): Surgery Radiation Chemo Tamoxifen Armedex

Date of Last Treatment: \_\_\_\_\_ Has it spread? (Circle one) YES NO If yes, where? \_\_\_\_\_

Have you ever been diagnosed with any of the following cancers (please check all that apply):

Ovarian Cancer  Uterine Cancer  Cervical Cancer  Other: \_\_\_\_\_

Previous Breast Surgeries, Procedures or Breast MRI's	Side: R/L/ Both	Outcome/Results (ie: Normal/Abnormal)	Date
Type (ie: Cyst Aspiration, Biopsy, Lumpectomy, Mastectomy, Breast Reduction, Breast Lift, Breast Implant Removal, etc.)			

**Do you have a family history of Breast Cancer:** YES NO

If yes, indicate age of diagnosis next to family member: Sister \_\_\_\_\_ Daughter \_\_\_\_\_ Mother \_\_\_\_\_

Paternal Grandmother \_\_\_\_\_ Maternal Grandmother \_\_\_\_\_ Other \_\_\_\_\_

**Do you have a family history of Ovarian, Uterine or Cervical Cancer:** YES NO

If yes, indicate family member, type and age of diagnosis: \_\_\_\_\_

**Have you ever been tested for the BRCA Gene?** YES NO

If Yes, please indicate results: BRCA 1  Pos  Neg BRCA 2  Pos  Neg

**Have any of your relatives been tested for the BRCA Gene?** YES NO

If Yes, list results: \_\_\_\_\_

**I understand that 10-20% of all breast cancers are not visualized on Mammograms.  
I will be responsible for follow-up with my health care provider regarding all future breast concerns.**

I Accept  I Decline

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

Patient Signature: \_\_\_\_\_ Todays Date: \_\_\_\_\_