

Breast Imaging Service

(Staff use only)
Xray number

Name: _____ Age: _____ Date of Birth: _____

Home Address: _____

Home Phone: (____) _____ Work Phone: (____) _____ Today's Date: _____

Previous Mammograms: No Yes If yes, when? _____
Where? _____

Are you pregnant? Yes No _____
Date of last menstrual cycle? _____

Ethnic Origin: Caucasian African American Hispanic
 American/Native Indian Asian or Pacific Islander Other

What is the REASON you are having a breast imaging exam (please select one)?

- This is a routine (screening) exam. I am not having any breast problems.
- This is an additional exam requested from my current screening exam.
- This is an additional exam requested from a recent study.
- This is a short interval follow-up requested from my last exam (1-11 months ago).
- I have breast implants, but I am not having any problems.
- This is a review of an outside study.
- I am going to have breast reduction.
- I am going to have radiation therapy.
- I have a personal history of breast cancer with breast conservation therapy.
- I am having the following **PROBLEM(S)**: (Circle **R** for Right or **L** for Left)

<input type="checkbox"/> R	<input type="checkbox"/> L	A new lump that can be felt	<input type="checkbox"/> R	<input type="checkbox"/> L	Previous lump or thickening finding
<input type="checkbox"/> R	<input type="checkbox"/> L	Bloody discharge	<input type="checkbox"/> R	<input type="checkbox"/> L	Nipple problem
<input type="checkbox"/> R	<input type="checkbox"/> L	Non-bloody discharge (old or new finding)	<input type="checkbox"/> R	<input type="checkbox"/> L	Pain in the breast
<input type="checkbox"/> R	<input type="checkbox"/> L	Difficult physical examination	<input type="checkbox"/> R	<input type="checkbox"/> L	Cancer elsewhere
<input type="checkbox"/> R	<input type="checkbox"/> L	Implant problem	<input type="checkbox"/> R	<input type="checkbox"/> L	Large nodes under my arm
<input type="checkbox"/> R	<input type="checkbox"/> L	Skin thickening or retraction noted during my clinical breast examination			

Check all of the following RISK FACTORS that are true for you:

- No one in my family has had breast cancer.
- My aunt had breast cancer. Age when diagnosed _____ Was she still having a period? No Yes
- My grandmother had breast cancer. Age when diagnosed _____ Was she still having a period? No Yes
- My cousin had breast cancer. Age when diagnosed _____ Was she still having a period? No Yes
- My mother had breast cancer. Age when diagnosed _____ Was she still having a period? No Yes
- My sister had breast cancer. Age when diagnosed _____ Was she still having a period? No Yes
- I do not know my family breast cancer history.
- I have had breast cancer.
- I have had endometrial cancer.
- I have had ovarian cancer.
- I have had a previous breast biopsy that showed a high risk lesion.
- I have been through menopause.
- I have never had children.
- I had my first child after age 30.

(continue on reverse)

Birth Control Pill No Yes If yes, are you currently using? _____ How long have you used? _____
Depovera No Yes If yes, are you currently using? _____ How long have you used? _____
Norplant No Yes If yes, are you currently using? _____ How long have you used? _____
Estrogen No Yes If yes, are you currently using? _____ How long have you used? _____
Progesterone No Yes If yes, are you currently using? _____ How long have you used? _____
Tamoxifen No Yes If yes, are you currently using? _____ How long have you used? _____

Enter your MENSTRUAL HISTORY:

Age when periods started _____ Age at left ovary removal _____
 Age at first full term pregnancy _____ Age at right ovary removal _____
 Age at natural menopause _____ Number of live births _____
 Age at hysterectomy _____

Previous PROCEDURES? Yes No

(If Yes, circle **R** for Right or **L** for Left)

R **L** Cyst aspiration Date: _____
R **L** Ultrasound core biopsy Date: _____
R **L** Excisional biopsy (noncancerous) Date: _____
R **L** Stereotactic biopsy Date: _____
R **L** Lumpectomy for cancer Date: _____
R **L** Mastectomy Date: _____
R **L** Radiation therapy Date: _____
R **L** Breast reduction Date: _____
R **L** Implant removed Date: _____

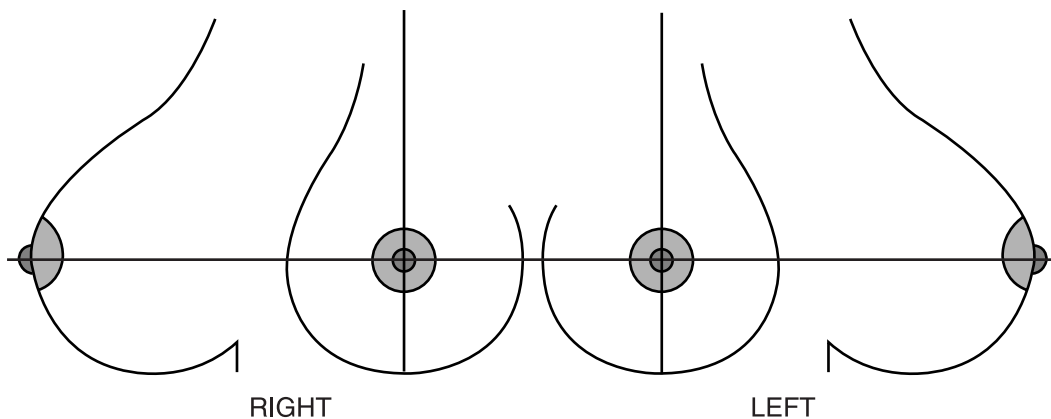
Do you have IMPLANTS? Yes No

(If Yes, circle **R** for Right or **L** for Left)

R **L** I don't know the specific type Date: _____
R **L** Silicone gel implant Date: _____
R **L** Saline implant Date: _____
R **L** Combination implant Date: _____
R **L** Pre-pectoral implant Date: _____
R **L** Retro-pectoral implant Date: _____

Have you ever received chemotherapy for any type of cancer? Yes No

----- For Office Use Only Below This Line -----



Technologist: _____

Disinfectant of compression devices