PATIENT INFORMATION – BREAST IMAGING CENTER – THE EMORY CLINIC

Today's Date: ____________________ **X Ray No.** ___________________

Name ________________________ Birthdate ____________ Age ______

Phone ______________ Alt Phone ______________ Doctor ______________

PRIOR MAMMOGRAM? ________ WHEN & WHERE ______________________

FAMILY HISTORY OF BREAST CANCER
(GIVE AGE WHEN FOUND):

SELF ________ YRS DAUGHTER ______ YRS

MOTHER ______ YRS GR.MOTHER ______ YRS

SISTER ______ YRS

AGE AT 1ST PERIOD __________

AGE AT 1ST PREGNANCY________

AGE AT MENOPAUSE __________

TAKING HORMONES, ESTROGEN? ___YES ____NO IF YES, WHEN STARTED? __________

HISTORY OF CHEMOTHERAPY? ___YES ____NO

SURGICAL PROCEDURES/HISTORY:

	LEFT BREAST	RIGHT BREAST
RADIATION		
MASTECTOMY/DATE		
LUMPECTOMY/DATE Cancer diagnosis		
BIOPSY, BENIGN/DATE Needle or Surgical		
IMPLANTS		
REDUCTION		
OTHER		

NEW **BREAST PROBLEMS – PLEASE DESCRIBE AND GIVE LOCATION:**

	LEFT BREAST	RIGHT BREAST
CURRENT LUMPS New since last mammogram		
RECENT PAIN Describe		
RECENT NIPPLE DISCHARGE Color		
SKIN PROBLEMS		

Other Problems (history of cysts, etc.)_______________________________________

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Comments: ____

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