Age: _______ Sex: ______ Height: _________ Weight: _________ Name: ____________________

Reasons for Today's Exam

☐ **Screening Exam (No Breast Symptoms)**

☐ Breast Symptoms if Present:

Thickening: R / L / Both	Nipple Retraction: R / L / Both
Skin Problem: R / L / Both	Lump: R / L / Both
Pain: R / L / Both	Discharge: R / L / Both
Swelling: R / L / Both	

☐ Follow-up of Previous Exam: R / L / Both

☐ Other (Describe): ____________________

Personal History

Yes / No Previous Mammogram: Date: ____________ Location: ____________

Yes / No Previous Breast Ultrasound: Date: ____________ Location: ____________

Yes / No Previous Breast MRI: Date: ____________ Location: ____________

Yes / No Personal History of Breast Cancer: R / L / Both Age/Year: ____________

Yes / No Personal History of Other Cancer: Type: ____________ Age/Year: ________

Yes / No Have you been tested for the Breast Cancer Genes (BRCA)?

If yes, what were the results? Positive / Negative

Yes / No Have you had genetic counseling?

Yes / No Have you had any of the following Procedures? If Yes, please indicate below:

Lumpectomy:	R / L / Both	Age/Year: ______	Implants: R / L / Both	Saline/Silicone		Age/Year: ______
Mastectomy:	R / L / Both	Age/Year: ______	Breast Reduction:	R / L / Both		Age/Year: ______
Radiation Therapy:	R / L / Both	Age/Year: ______	Cyst Aspiration:	R / L / Both		Age/Year: ______
Chemotherapy:	R / L / Both	Age/Year: ______	Needle Core Biopsy:	R / L / Both		Age/Year: ______
Tram Flap:	R / L / Both	Age/Year: ______	Surgical Biopsy:	R / L / Both		Age/Year: ______

Date of Last Menstrual Period: ______ If Post-Menopausal, at what age? ______ Age at First Menstrual Period: ______

Number of Pregnancies: ________ Age at First Pregnancy: ________ Age at First Live Birth: ________

Yes / No Have you had a Hysterectomy: Age/Year: ________ Partial: ________ Complete: ________

Yes / No Are you currently taking Hormones or Birth Control Pills? Type: ________ Began: Age/Year: ________

Yes / No Past use of Hormones or Birth Control Pills? Type: ____________

Began: Age/Year: ________ End: Age/Year: ________

Yes / No Are you currently Breastfeeding, Pregnant, or Possibly Pregnant? ____________

Name / MR # / Label

Family History of Cancer Unknown/Adopted: ____________

Mother: Breast/Ovarian Age: ________ Grandmother: Breast/Ovarian Age: ________

Sister: Breast/Ovarian Age: ________ Daughter: Breast/Ovarian Age: ________

Other Relative: ____________

Yes / No Ashkenazi Jewish Heritage?

Yes / No Do you have MRSA, shingles, latex allergy or a skin rash? ____________

Yes / No Do you perform breast self-exams?

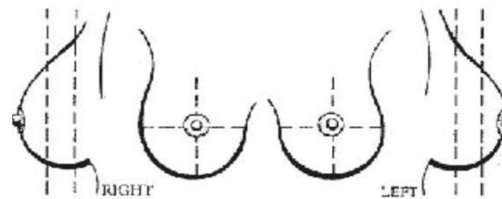
Patient's Signature: ____________ Date: ________ Time: ________

Patient's Preferred Phone Number: ____________

Referring Provider: ____________ Phone: ________

(Staff Use Only) Technologist: ________ Education Provided: ________ Date: ________ Time: ________

Tech Notes:



If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter Accepted ____________ ☐ Interpreter Refused

(Name/Number of Person/Services Chosen/Used)