Hastings IMAGING CENTER

Name: _____ **Age:** _____ **Date:** _____
Date of birth: _____ **Referring physician:** _____

1. **Have you had a previous mammogram?** yes no
   If yes, where? _____ _____
2. **When was your last clinical breast exam?** _____
3. **Do you do self breast exams?** yes no
4. **Do you have a family history of breast ca** yes no
   If yes, who? _____
5. **Do you have any breast lumps?** yes no **If yes, Right or Left (circle one)**
6. **Do you have any breast cysts?** yes no **If yes, Right or Left (circle one)**
7. **Do you have breast pain?** yes no **If yes, Right or Left (circle one)**
8. **Do you have nipple discharge?** yes no **If yes, Right or Left (circle one)**
9. **Do you have inverted nipples?** yes no **If yes, Right or Left (circle one)**
10. **Have you had breast cancer?** yes no **If yes, Right or Left (circle one)**
    If yes, did you have chemotherapy and/or radiation thera yes no
11. **Have you been breast feeding in the last 6 months?** yes no
12. **Do you have an insulin pump?** yes no

CHECK ANY OF THE FOLLOWING PROCEDURES YOU HAVE HAD:

Implants	**Right** _____	**Left** ___	**Type:** saline silicone
Breast reduction	**Right** _____	**Left** _____	
Cyst aspiration	**Right** _____	**Left** _____	
Needle biopsy	**Right** _____	**Left** _____	
Surgical biopsy	**Right** _____	**Left** _____	
Lumpectomy	**Right** _____	**Left** _____	
Mastectomy	**Right** _____	**Left** _____	

Are you pregnant or is there any chance you may be pregnant? yes no

_____
patient signature

Technologist's comments:

tech's initials _____

right left