



Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ 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 cancer?  yes  no

If yes, who? \_\_\_\_\_ At what age were they diagnosed? \_\_\_\_\_

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 therapy?  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 \_\_\_\_\_
- Breast reduction Right \_\_\_\_\_ Left \_\_\_\_\_
- Cyst aspiration Right \_\_\_\_\_ Left \_\_\_\_\_
- Needle biopsy Right \_\_\_\_\_ Left \_\_\_\_\_
- Surgical biopsy Right \_\_\_\_\_ Left \_\_\_\_\_
- Lumpectomy Right \_\_\_\_\_ Left \_\_\_\_\_
- Mastectomy Right \_\_\_\_\_ Left \_\_\_\_\_

- Type:  saline  silicone
- If yes, when? \_\_\_\_\_
- If yes, when? \_\_\_\_\_
- If yes, when? \_\_\_\_\_
- If yes, when? \_\_\_\_\_
- If yes, when? \_\_\_\_\_
- If yes, when? \_\_\_\_\_

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

\_\_\_\_\_  
patient signature

Technologist's comments:

right      left

tech's initials \_\_\_\_\_