

_____, _____, _____, _____, _____
Patient's Last Name Patient's First Name M.I. Age Date of Birth
 (_____) - _____ (_____) - _____ (_____) - _____
Home Telephone Number Work Telephone Number Cell Phone Number

Date of Last Mammogram: _____ **Name of other facility:** _____

RISK FACTORS:

Personal History of Breast Cancer? Yes No
 Family History of Breast Cancer? Yes No

If YES, Relationship: _____ Age at Diagnosis: _____
 Relationship: _____ Age at Diagnosis: _____
 Relationship: _____ Age at Diagnosis: _____

CURRENT COMPLAINTS: (Please check all that apply)

Breast Lump? Yes No Rt. Lt
 Breast Pain? Yes No Rt. Lt
 Nipple Discharge? Yes No Rt. Lt

Annual screening Mammogram, I have no complaint today.

Other: _____

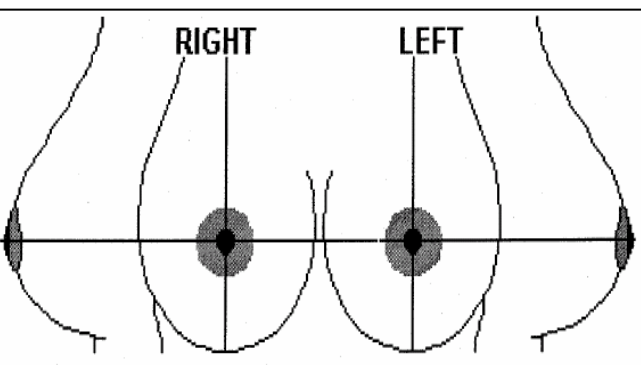
BREAST HISTORY: (Please complete if you have ever had breast surgery or treatment)

Implants: Rt. Lt. Silicone Saline Date: _____
 Cyst Aspiration: Rt. Lt. Benign Malignant Date: _____
 Needle Biopsy: Rt. Lt. Benign Malignant Date: _____
 Surgical Biopsy: Rt. Lt. Benign Malignant Date: _____
 Lumpectomy: Rt. Lt. Benign Malignant Date: _____
 Mastectomy: Rt. Lt. Benign Malignant Date: _____
 Chemotherapy: Yes No Date Started: _____ Date Ended: _____
 Radiation Therapy: Yes No Date Started: _____ Date Ended: _____

HORMONE HISTORY:

Prior/current use Oral Contraceptives? Yes No Date started: _____
 Currently using Hormones? Yes No Date started: _____
 First day of last menstrual period _____

To the best of my knowledge, I am not pregnant. _____ **Date** _____



Patient's Signature _____ **Date** _____

Technologist Notes: