

Patient Information (to be filled out by patient):

Patient's Last Name	First Name	Previous Last Name	Date of Birth
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Have you ever had a mammogram, breast ultrasound or breast MRI? **Yes** **No** If yes, where and when was it performed? _____

What was the date of the first day of your last menstrual period? _____

Are you currently using any hormones? **Yes** **No** If yes what type and for how long? _____

Have you ever had breast surgery or other breast procedures? **Yes** **No** If yes, please mark type and list dates:

Type of Procedure	Dates	Which Breast?	Dates Procedures Performed?
Biopsy/Aspirations		Left or Right	Needle or Surgical
Augmentation (Implants)		Left or Right	Saline or Silicone
Reduction/Lift		Left or Right	
Mastectomy		Left or Right	
Lumpectomy (due to Cancer)		Left or Right	
Radiation Therapy		Left or Right	

Personal/Family History

Have you ever been diagnosed with breast cancer? **Yes** **No**
If yes, when, by what type of biopsy and which breast? _____

Has your blood-related parent, sibling, or child ever had breast cancer? **Yes** **No**
If yes, who was it and at what age was the diagnosis? _____

Current History

Any possibility you may be pregnant? **Yes** **No**

Are you currently breastfeeding? **Yes** **No**

Have you tested positive for BRCA 1 or BRCA 2? **Yes** **No** or **NA** (have not been tested)

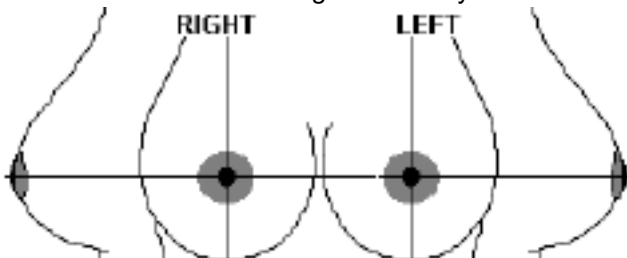
What is the reason for this examination? Please check the most appropriate blanks below:

Screening I am not aware of any breast problems I have a strong family history of breast cancer,
I am BRCA 1 and/or BRCA 2 positive (check as appropriate), other

Not routine, I have a breast lump skin thickening or dimpling nipple changes nipple discharge
follow-up to recent mammo or breast sono new diagnosis of breast cancer other

Please describe in more detail any areas checked above:

For Technologist Use Only:



Technologist please document areas such as lump, scar, site of biopsy, etc.