BREAST HISTORY

Today's Date: ____________

NAME: ____________ ID#: ____________

Date of Birth ____________ Age: ________ Referring Physician: ____________

CURRENT BREAST PROBLEMS

- ☐ NONE
- ☐ Lump ☐ Left ☐ Right
- ☐ Tenderness ☐ Left ☐ Right
- ☐ Nipple Secretion ☐ Left ☐ Right
- Color ____________
- ☐ Burning ☐ Left ☐ Right
- ☐ Pain ☐ Left ☐ Right
- ☐ Other Please describe ____________

PREVIOUS MAMMOGRAMS

- ☐ NONE
- Date of last mammogram ____________
- Where was it done ____________

IMPLANTS

☐ NONE

- ☐ Saline ☐ Left ☐ Right ☐ Pre-pectoral ☐ Post-pectoral
- ☐ Silicone Gel ☐ Left ☐ Right ☐ Pre-pectoral ☐ Post-pectoral
- ☐ Double Lumen ☐ Left ☐ Right ☐ Pre-pectoral ☐ Post-pectoral
- ☐ Augmentation ☐ Left ☐ Right ☐ Pre-pectoral ☐ Post-pectoral

PERSONAL HISTORY

Are you pregnant? ☐ Yes ☐ No Number of Pregnancies: ________ Have you had a Hysterectomy? ☐ Yes ☐ No

Date of last menstrual period ________ Number of Births: ________ Date (or Age) ________

Age at First Period: ________ Age at First Pregnancy: ________ Were your ovaries removed? ☐ No ☐ Left ☐ Right

Age at Menopause ________ Date (or Age) ________

BREAST SURGERY

☐ NONE

- ☐ Biopsy ☐ Left Date ________ ☐ Right Date ________
- ☐ Lumpectomy (cancer) ☐ Left Date ________ ☐ Right Date ________
- ☐ Lumpectomy w/radiation ☐ Left Date ________ ☐ Right Date ________
- ☐ Mastectomy ☐ Left Date ________ ☐ Right Date ________
- ☐ Implants ☐ Left Date ________ ☐ Right Date ________
- ☐ Reduction ☐ Left Date ________ ☐ Right Date ________

RISK FACTORS

Have you had any kind of cancer? ☐ Yes ☐ No If yes, specify: ____________

Family history of breast cancer? ☐ NONE

- ☐ Mother Age at diagnosis ________ ☐ Post Menapausal Bilateral? ☐ Yes ☐ No
- ☐ Sister Age at diagnosis ________ ☐ Post Menapausal Bilateral? ☐ Yes ☐ No
- ☐ Daughter Age at diagnosis ________ ☐ Post Menapausal Bilateral? ☐ Yes ☐ No
- ☐ Other Age at diagnosis ________ ☐ Post Menapausal Bilateral? ☐ Yes ☐ No

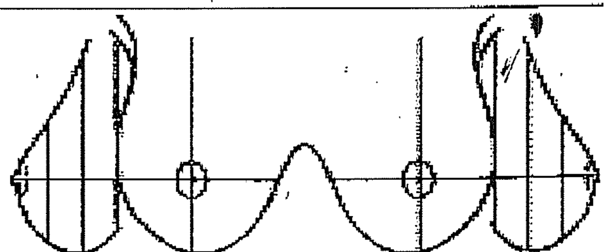
Do you have a Family History of Other Cancer? ☐ Yes ☐ No If yes, specify: ____________

HORMONES/CONTRACEPTIVES

Type: ________	Type: ________	Type: ________
Currently Using? ☐ Yes ☐ No	Currently Using? ☐ Yes ☐ No	Currently Using? ☐ Yes ☐ No
1st Use (Date or Age): ________	1st Use (Date or Age): ________	1st Use (Date or Age): ________
Last Use (Date or Age): ________	Last Use (Date or Age): ________	Last Use (Date or Age): ________
Longest Continuous Use: ________	Longest Continuous Use: ________	Longest Continuous Use: ________

THERAPY

- Chemotherapy ☐ Yes ☐ No Dates ________
- Radiation therapy ☐ Yes ☐ No Dates ________
- Hormonal Treatment of Cancer ☐ Yes ☐ No Dates ________
- Radiation and Chemotherapy ☐ Yes ☐ No Dates ________
- Radiation and Hormonal Therapy ☐ Yes ☐ No Dates ________



# of FilmsUsed: ____________ ☐ Screening ☐ Diagnostic ☐ Bilateral ☐ Left ☐ Right

Repeat Films/Views/Reason: ____________ ☐ Infection Control Technologist ____________