

BREAST IMAGING PATIENT HISTORY FORM

Date: _____

Ordering Physician: _____

Your Preferred Phone Number: _____



Reason for Today's Exam:		<input type="checkbox"/> Routine Screening	<input type="checkbox"/> New Symptom or Clinical Finding	<input type="checkbox"/> Other: _____
1.	Do you use an insulin pump?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
2.	Have you had breast imaging studies at another facility?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	If so, where: _____			
3.	Do you have implants?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	If yes, what type?	<input type="checkbox"/> Saline	<input type="checkbox"/> Silicone	<input type="checkbox"/> Other: _____
4.	Are you currently breastfeeding or are you possibly pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	What is the date of your last menstrual period? _____			
5.	Have you completed menopause?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	If yes, at what age? _____			
6.	Have you given birth?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	If yes, what is the year of your first child's birth? _____			
7.	What is the date of your last clinical breast exam? _____			
8.	I, or my healthcare provider, feel/notice a new:			
	<input type="checkbox"/> Palpable lump or thickening	<input type="checkbox"/> Focal pain or tenderness	<input type="checkbox"/> Nipple discharge	<input type="checkbox"/> Other: _____
9.	Have you had cancer of the uterus, cervix, ovaries or elsewhere?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	If yes, where? _____			
10.	Have you had childhood radiation for lymphoma?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
11.	Have you been diagnosed with breast cancer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	If so, have you had any of the following treatments?			
	<input type="checkbox"/> Lumpectomy	<input type="checkbox"/> Left	<input type="checkbox"/> Right	
	<input type="checkbox"/> Mastectomy	<input type="checkbox"/> Left	<input type="checkbox"/> Right	
	<input type="checkbox"/> Radiation Therapy (External Beam or Brachytherapy)	<input type="checkbox"/> Left	<input type="checkbox"/> Right	
	<input type="checkbox"/> Chemo Therapy			
	<input type="checkbox"/> Chemoprevention Therapy			
	Have you had an axillary node dissection?	If yes, <input type="checkbox"/> Left		<input type="checkbox"/> Right
	<i>(If possible please do not place IV for contrast in the same side of the dissection)</i>			
12.	Have you had breast surgery or a breast procedure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Ultrasound Guided Biopsy	<input type="checkbox"/> Left	<input type="checkbox"/> Right	
	Cyst Aspiration	<input type="checkbox"/> Left	<input type="checkbox"/> Right	
	Stereotactic Biopsy	<input type="checkbox"/> Left	<input type="checkbox"/> Right	
	MRI Biopsy	<input type="checkbox"/> Left	<input type="checkbox"/> Right	
	Surgical/ Excisional Biopsy	<input type="checkbox"/> Left	<input type="checkbox"/> Right	
	Other: _____			
13.	Do you have a family history of breast cancer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
	If yes, who in your family had breast cancer?	<input type="checkbox"/> Aunt, cousin, grandmother		
		<input type="checkbox"/> Post-menopausal mother, sister, daughter		
		<input type="checkbox"/> Pre-menopausal mother, sister, daughter		
14.	Do you have a breast cancer "gene" in your family?			

To the best of my knowledge, the above information is correct.

Patient Signature: _____ Date: _____ Technologist Initials: _____