NAME: ____ **DOB:** ___________
AGE: _____

Have you had a previous mammogram? Yes No
When? ______________Where? ______________________________

Date of last breast examination by your Doctor?______________________

SYMPTOMS
Palpable Lump Yes No Right___ Left____ How long?____________
Nipple Discharge Yes No Right___ Left____ How long/Color?________
Do you have breast implants? Yes No
Have you had a breast reduction? Yes No

FAMILY HISTORY
Has any blood relative had breast cancer: Yes No Age?
Mother _____ Daughter______Grandmother______ ______
Sister______ Aunt_______ Cousin ________ ______
Have you had breast surgery? Yes No
If yes:
Mastectomy Right____ Left____ Surgery date_______
Biopsy Right____ Left____Surgery date_______Results_____________
Other Right____Left_____Surgery date______ Results_____________

Are you taking birth control pills or female hormones? Yes No
How long? ____________ What type? ____________________________

Have you had any type of cancer? Yes No What type? ______________________________

<u>MENSTRUAL HISTORY</u>
Age menstrual cycle began__________
Age menstrual cycle ended__________

<u>CHILDBIRTH HISTORY</u>
Age at first pregnancy______
Number of pregnancies_____

Previous films not available_________

TECH ID_________# Images_________

Mark area of clinical concern

Comments: