



Tech Initials: _____

MRN #: _____

PATIENT INFORMATION

Name: _____ Date of Birth: _____ Age: _____ Date of last mammogram: _____

Reason for today's exam: First mammogram ever Annual mammogram
New symptoms may require Doctor's order New symptom/problem 6-month follow-up

*Describe your *new* breast problem and how long you have had it (if applicable): _____

MEDICAL INFORMATION AND RISK ASSESSMENT

FAMILY HISTORY

1. Has anyone in your **Family** been diagnosed with **breast** cancer? Yes No

Mother/Age____ Daughter/age____ Sister/age____

✓ If Yes , please check the relative and age at time of diagnosis: Aunt/Age____ → Maternal Paternal

Grandmother/Age____ → Maternal Paternal

PERSONAL HISTORY

1. **Race:** White African American Hispanic Unknown
 Asian-American American Indian/Alaskan Native

2. **Ethnicity (If applicable):** Chinese Japanese Filipino Hawaiian
 Other Pacific Islander Other Asian-American


3. Have **you** previously been diagnosed with **breast** cancer? Yes No

4. Do **you** have a history of **female** cancer? (*Ovarian, uterine, cervical*) Yes No

5. Known BRCA1 or BRCA2 mutation or similar genetic syndrome? Yes No

6. **Do you take hormones?** Yes No

✓ If Yes , please check the ones you are currently using:
 Birth control Estrogen Progesterone
 Tamoxifen Evista Arimidex

 Length of time on hormones: _____ Months Years

7. Age at **first** menstrual period? Age 7-11 Age 12-13 Age 14 or older

8. **Date of your last** menstrual period: _____

9. Are you **post menopausal**? Yes No

10. Are you pregnant? Yes No

11. Age when you had your first child? No Births Under 20 Age 20-24
 Age 25-29 Age 30 + Unknown

BREAST PROCEDURES

1. History of breast biopsy? Yes No Rt Lt Date(s): _____

✓ If Yes , how many times? 1 More than 1

Did any of the biopsies show *atypical* hyperplasia?
(or other high risk marker on biopsy?) Yes No

2. History of mastectomy? Yes No
 Rt Lt Bilateral Date: _____

3. History of lumpectomy? Yes No
 Rt Lt Bilateral Date: _____

4. Treatment: Chemotherapy *with* radiation
 without radiation

5. History of breast reduction surgery? Yes No Date: _____

6. History of breast implant surgery? Yes No Date: _____

Patient Signature: _____

Date: _____