

LENOX HILL RADIOLOGY & MEDICAL IMAGING ASSOCIATES P.C.

BREAST HISTORY & MAMMOGRAM SCREENING SHEET

COMPLETED BY PATIENT

PATIENT NAME: _____ TODAY'S DATE: _____

DATE OF BIRTH: _____

PHONE # (H): _____ (W): _____ DATE OF LAST MAMMOGRAM: _____

WHERE: _____ REFERRING PHYSICIAN: _____

What is the reason for having this breast exam?

- This is a routine exam. I AM NOT HAVING ANY BREAST PROBLEMS.
- This is a short interval follow-up requested from my last exam (1-11 months ago).
- I have BREAST IMPLANTS, but I am not having any problems. Type of implant: _____
- I am having the following new problem (s): *(please check R for right or L for left)*

<input type="checkbox"/> New lump that can be felt	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Breast pain	<input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Other NEW thickening	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Nipple problem	<input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Bloody nipple discharge	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Non-bloody spontaneous nipple discharge	<input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Other _____	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Large Nodes under my arm	<input type="checkbox"/> R <input type="checkbox"/> L
- I have a personal history of cancer. Date: _____ Location: _____
- Any medical conditions: _____

DATE OF LAST PHYSICAL BREAST EXAM PERFORMED BY YOUR PHYSICIAN: _____

Please enter your menstrual history (where applicable):

Age when periods started _____	Age at first full term pregnancy _____
Age at natural menopause _____	Number of live births _____
Age at hysterectomy _____	Are you pregnant? _____
Were your ovaries removed? <input type="checkbox"/> YES <input type="checkbox"/> NO	Last Menstrual period: _____
Are you taking any of the following? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> Estrogen Replacement Therapy? Age first used _____ Age last used _____	
<input type="checkbox"/> Tamoxifen/Arimidex Age first used _____ Age last used _____	
<input type="checkbox"/> Progesterone? Age first used _____ Age last used _____	
<input type="checkbox"/> Hormonal Contraceptives (Birth control) Age first used _____ Age last used _____	

IMPORTANT: Check the following THAT ARE TRUE FOR YOU:

- No one in my family has had breast cancer.
- My aunt, grandmother, cousin, father, uncle had breast cancer. Maternal or paternal
- My mother, sister had breast cancer after their periods had stopped. Age at diagnosis _____
- My mother, sister had breast cancer while they were still having their periods. Age at diagnosis _____
- I have had breast cancer. R L

Have you ever had any of the following procedures: <input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> R <input type="checkbox"/> L Breast Reduction Date: _____	
<input type="checkbox"/> R <input type="checkbox"/> L Cyst Aspiration Date: _____	
<input type="checkbox"/> R <input type="checkbox"/> L Needle biopsy Date: _____	
<input type="checkbox"/> R <input type="checkbox"/> L Excisional biopsy Date: _____	
<input type="checkbox"/> R <input type="checkbox"/> L Lumpectomy for Cancer Date: _____	
<input type="checkbox"/> R <input type="checkbox"/> L Mastectomy Date: _____	
<input type="checkbox"/> R <input type="checkbox"/> L Radiation Therapy Date: _____	
<input type="checkbox"/> R <input type="checkbox"/> L Mastopexy (breast lift) Date: _____	

Screened by: _____	Entered in Mammobase by: _____
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I verify that the answers I have provided to questions on this form are correct and understand that withholding information or inaccurate information may adversely affect the interpretation of this exam.

Patients signature: _____ Date: / /