NEW YORK PRIVATE MEDICAL IMAGING

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 a personal history of cancer. Date: __________________ Location: ____________________

☐ I am having the following new problem (s): *(please check R for right or L for left)*

☐ New lump that can be felt	☐ R ☐ L	☐ Breast pain	☐ R ☐ L
☐ Other NEW thickening	☐ R ☐ L	☐ Nipple problem	☐ R ☐ L
☐ Bloody nipple discharge	☐ R ☐ L	☐ Non-bloody spontaneous nipple discharge	☐ R ☐ L
☐ Other ____________________	☐ R ☐ L	☐ Large Nodes under my arm	☐ R ☐ L

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

Are you taking any of the following? ☐ YES ☐ NO

☐ Estrogen Replacement Therapy?	Age first used ________	Age last used ________
☐ Tamoxifen/Arimidex	Age first used ________	Age last used ________
☐ Progesterone?	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

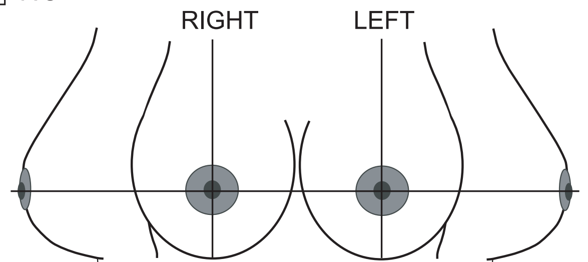
☐ My ☐ mother, ☐ sister had breast cancer after their periods had stopped. Age at diagnosis ____________

☐ 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: ☐ YES ☐ NO

☐ R ☐ L	Cyst Aspiration	Date: ________
☐ R ☐ L	Needle biopsy	Date: ________
☐ R ☐ L	Excisional biopsy	Date: ________
☐ R ☐ L	Lumpectomy for Cancer	Date: ________
☐ R ☐ L	Mastectomy	Date: ________
☐ R ☐ L	Radiation Therapy	Date: ________



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: / /