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 BREAST IMPLANTS, but I am not having any problems. Type of implant: _____

☐ 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: _____

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? ☐ YES ☐ NO Last Menstrual period: _____

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 _____
☐ 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

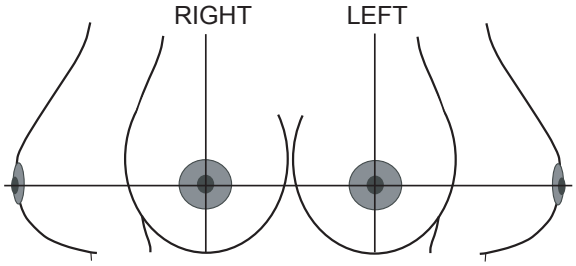
☐ My ☐ mother, ☐ sister had breast cancer after their periods had stopped. Age at diagnosis _____

☐ 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: ☐ YES ☐ NO

☐ R ☐ L	Breast Reduction	Date: _____
☐ 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: _____
☐ R ☐ L	Mastopexy(breast lift)	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: / /