RADNET, inc

Facility: _____

Breast History Form

Version 1.0
Effective Date: July 24, 2014

Name: _____ Age: _____ Date: _____

Do you have any problems or changes you are concerned with today? Yes No

If yes, please describe: _____

Have you ever had a mammogram or ultrasound before? Yes No If yes, When? _____ Where? _____

Have you ever had a breast MRI before Yes No If yes, When? _____ Where? _____

Did you have children **before** age 30? Yes No

Are you pregnant? Yes No

Have you breast fed in the last **6 months**? Yes No

Are you still menstruating? Yes No

Age at first period _____ Date of last period ____/____/_____ If not menstruating age at last period? _____

Are you taking any prescription hormones, bio-identical hormones, birth control pills or over the counter products? Yes No If yes, what kind? _____ Change in dose? _____

Have you had a hysterectomy or ablation of the uterus? Yes No If yes, what age? _____

Have your ovaries been removed? Yes No If yes, what age? _____

Do you have a family history of breast cancer? Yes No

Age at Diagnosis: Mother: ____ Sister: ____ Daughter: ____ Aunt: ____ Grandmother: ____ Cousin: ____ Other: _____

Have you **personally** had any of these cancers?

Type: Uterine ❑ Yes ❑ No Ovarian ❑ Yes ❑ No Colon ❑ Yes ❑ No Pancreatic ❑ Yes ❑ No Other _____

Have you **personally** had breast cancer? Yes No Year of diagnosis _____ Age at diagnosis _____

Treatment: ❑ None ❑ Surgery ❑ Chemotherapy ❑ Radiation [❑ Whole breast ❑ Partial breast]

Are you taking Tamoxifen, Arimidex or any other drugs for breast cancer treatment? Yes No

Have you had any genetic testing? Yes No

BRCA 1 ❑ Positive ❑ Negative BRCA 2 ❑ Positive ❑ Negative

Breast Surgical History			**Indicate Side**		**Date(s)**
Have you ever had a surgical breast biopsy?	Yes	No	❑ Right	❑ Left	
Have you ever had a needle biopsy of the breast?	Yes	No	❑ Right	❑ Left	
Breast Cancer Lumpectomy	Yes	No	❑ Right	❑ Left	
Mastectomy	Yes	No	❑ Right	❑ Left	
Breast Reduction	Yes	No	❑ Right	❑ Left	
Augmentation (circle one – Saline or Silicone Implants or Silicone injections)			❑ Right	❑ Left	
Other (describe) :					

1. On review of your screening mammogram, if an area needs further evaluation, we will contact you to schedule an appointment. (There is an additional charge for these views).
2. If an ultrasound exam is recommended, this is considered a separate study and is billed separately.
3. In the event that additional views and/or breast ultrasound is performed on the same day as your screening mammogram, be aware that there is an additional charge for these exams.

PLEASE BE ADVISED THAT A DIAGNOSTIC MAMMOGRAM AND/OR BREAST ULTRASOUND ARE NOT CONSIDERED TO BE A PREVENTATIVE EXAM AND MAY INCUR ADDITIONAL OUT OF POCKET EXPENSE.

To the best of my knowledge, *all of the above is true and correct.*

Patient Signature: _____ Date: _____/_____/_____