BREAST HISTORY

Patient Name ________________

Male ______ Female ______ Height ________ Weight (lbs.) __________

Age _______ DOB ________________ **MRN** ________________

History

Have you had any new problems since your last mammogram? If yes, please describe.

____

____

Do you have breast implants? ○ No ○ Yes

Have you had breast reduction surgery? ○ No ○ Yes

How much weight have you gained/lost in the past year? ______ lbs.

Do you have nipple discharge? ○ No ○ Left ○ Right **If yes, what color is the discharge?** __________

Do you have breast thickening? ○ No ○ Left ○ Right

Do you have a lump in either of your breasts? ○ No ○ Left ○ Right

Do you have a history of cancer? ○ No ○ Yes

Breast cancer: ○ Left ○ Right When? ________________

Ovarian cancer: ○ No ○ Yes When? ________________

Other cancer: ○ No ○ Yes When? ________________

If yes, what type of non-surgical cancer treatments have you had in the past?

○ Radiation Therapy When? ______________ ○ Hormone Therapy When? ______________

○ Chemotherapy When? ______________ ○ Alternative Medicine When? ______________

Risk Factors

Treatment for lymphoma before age 40? ○ No ○ Yes

Do you have a BRCA gene mutation? ○ No ○ Yes

Previous breast biopsy demonstrating LCIS: ○ No ○ Yes

Previous breast biopsy demonstrating Atypical Hyperplasia: ○ No ○ Yes

Previous benign breast biopsy? ○ No ○ Left ○ Right When? ______________

Family Risk Factors

Family history of breast cancer and age when diagnosed:

○ Mother, _____ yrs. ○ Sister, _____ yrs. ○ Daughter, _____ yrs. ○ Grandmother, _____ yrs

○ Aunt, _______ yrs. ○ Male Family Member, _____ yrs. ○ No family history of breast cancer

Medications

List any medications you currently take, along with dosage for each:

________________ ________________

________________ ________________

________________ ________________

________________ ________________

Surgical History

Please list all operations, surgeries, or other significant medical procedures you have had during your lifetime, with approximate dates (including cancer treatment): ○ I have not had any significant procedures

____

____

____

Women Only

Are you pregnant? ○ No ○ Yes ○ N/A ______________

Is there a chance you may be pregnant? ○ No ○ Yes ○ Don't know

Are you currently breast feeding? ○ No ○ Yes Date of last breast feeding ______________

Date of last menstrual period ______________

Patient Signature ________________________ **Date** ______________

Reviewed by Technologist: ________________ **Date** __________ **Time** ________ **am / pm**

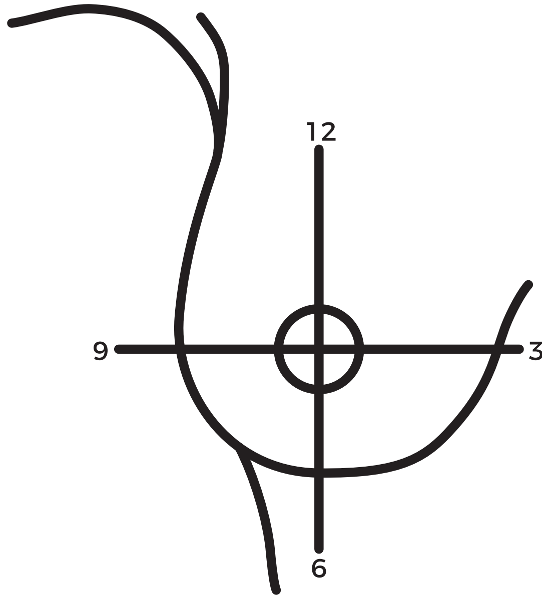
Reviewed by Sonographer: ________________ **Date** __________ **Time** ________ **am / pm**

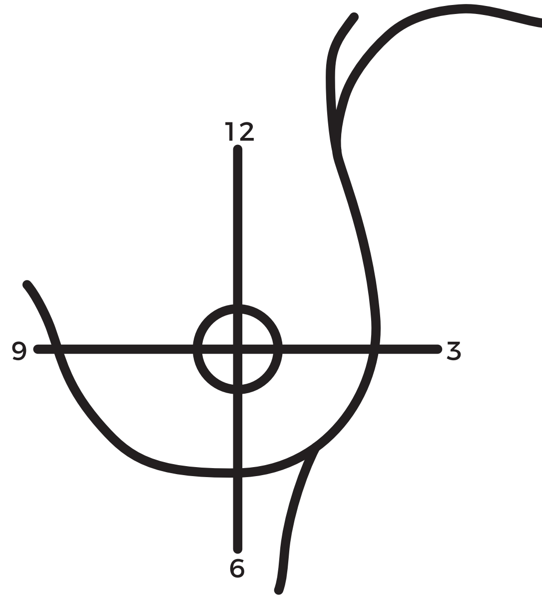
Advanced Radiology

Patient Name ______________________________

Male ______ Female ______ Height ________ Weight (lbs.) ___________

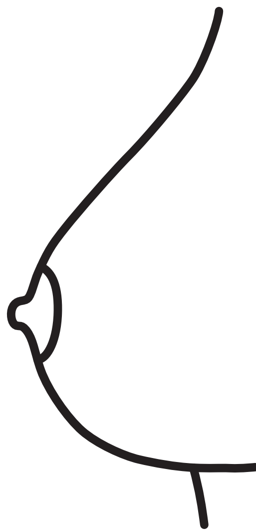
Age _______ DOB ____________________ **MRN** _____________________





RIGHT BREAST

LEFT BREAST



Technologist Notes: ____

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Technologist Signature: ______________________ **Date** ____________ **Time** _______ **am / pm**