

PATIENT HISTORY FORM

Date: _____
 Name: _____ Age: _____ Date of Birth: _____
 Previous names: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home phone: _____ Work Phone: _____ Cell Phone: _____
 Referring physician: _____
 Reason for mammogram/exam: _____
 Have you had a previous mammogram: Yes No Where: _____ When: _____
 Have you had a prior breast ultrasound: Yes No Where: _____ When: _____
 Weight gain or loss since last mammogram: Yes No Weight: _____
 Age of first menstrual cycle: _____ Age of first full term pregnancy: _____
 Current Medications: _____

YES NO

| | | | | |
|--------------------------|--------------------------|--------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | New breast lump since last mammogram | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both | How long? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | New pain or tenderness | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both | Color/How long? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Nipple discharge | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both | When? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Breast Surgery | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both | When? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Breast needle biopsy | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both | |
| <input type="checkbox"/> | <input type="checkbox"/> | Implants (date: _____) | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you take any type of hormones? | Type: _____ | How long? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Is there any chance you are pregnant? | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had breast cancer? If yes, check all that apply: | | |
| | <input type="checkbox"/> | Left (Date: _____) | <input type="checkbox"/> Mastectomy <input type="checkbox"/> Lumpectomy <input type="checkbox"/> Reconstruction | <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Radiation |
| | <input type="checkbox"/> | Right (Date: _____) | <input type="checkbox"/> Mastectomy <input type="checkbox"/> Lumpectomy <input type="checkbox"/> Reconstruction | <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Radiation |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a family history of breast cancer? If yes, check all that apply: | | |
| | <input type="checkbox"/> | Mother | <input type="checkbox"/> Sister | <input type="checkbox"/> Grandmother <input type="checkbox"/> Other _____ |
| | | Age of diagnosis: _____ | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a family history of ovarian cancer? If yes, check all that apply: | | |
| | <input type="checkbox"/> | Mother | <input type="checkbox"/> Sister | <input type="checkbox"/> Grandmother <input type="checkbox"/> Other _____ |
| | | Age of diagnosis: _____ | | |

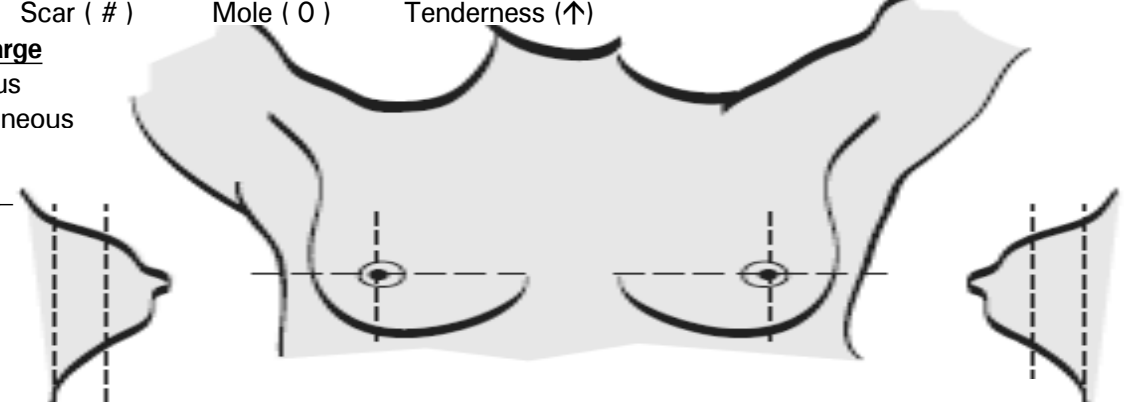
Patient Signature: _____ Date: _____

DO NOT WRITE BELOW THIS LINE

Lump (▼) Scar (#) Mole (0) Tenderness (↑)

Nipple Discharge

Spontaneous
 Not Spontaneous



Yes No Is this patient a suspected victim of abuse
 Yes No Patient tolerated exam
 Yes No Is this patient a fall risk
 Yes No Patient discharged without complaint

Comments: _____

Technologist: _____ Date _____ Time: _____

