PINK DOOR

Breast History Forms

BreastGyn Clinic
BREAST & GYNECOLOGICAL IMAGING

MUST COMPLETE YEARLY

Name _____ **Date of Birth:** _____ **PHONE NO.**_____

Name of the (*Physician)* on orders _____ SELF REFFERED (Y) *NO ORDERS

DATE OF LAST MAMMOGRAM: _____LOCATION OF LAST MAMMOGRAM_____

Reason for today's exam: [ ] First mammogram [ ] Annual Mammogram Diagnostic Mammogram [ ]

* [ ] New symptom/problem [ ] 6-month follow up

(PERSONAL HISTORY)

Age at *first* menstrual period: ____ Are you pregnant? _____ *currently* on birth control? _____
Age when you had your first child____ Number of Births___ Ovaries removed Y / N Hysterectomy Y / N
Do you take hormones? If (YES) please list the ones you are *currently* using: _____

BREAST IMPLANTS: (YES) OR (NO) ORIGINAL YEAR_____ ____REPLACED YEAR _____ BREAST REDUCTION: (R) (L) YEAR_____
SURGICAL BIOPSY: RIGHT LEFT BILATERAL YEAR _____ NEEDLE BIOPSY: RIGHT LEFT BILATERAL YEAR

LUMPECTOMY: RIGHT LEFT BILATERAL YEAR DIAGNOSED _____
MASTECTOMY: RIGHT LEFT BILATERAL YEAR DIAGNOSED_____
RADIATION THERAPY: Y N YEAR_____ CHEMOTHERAPY _____

(FAMILY HISTORY)

Has anyone in your *FAMILY* been diagnosed with breast/ovarian cancer (yes) or (no)

Relative and age at time of diagnosis_____

BREAST CONCERNS:

PLEASE ANSWER ALL QUESTIONS BELOW-DO NOT LEAVE BLANK

****PLEASE NOTE:** IF "YES" FOR ROUTINE SCREENING APPT YOU WILL BE RESCHEDULED*

ANY NEW breast problems: Y/N: Pain/discharge/nipple inversion/ (if so) how long? ___
Any NEW Breast Lump(s) Y/N Thickening/Skin Changes/ (if so) how long? ____

****PATIENT SIGNATURE*** _____ DATE: _____

PLEASE DO NOT WRITE BELOW:

BC#_____ SCREENING (2D) (3D) DX (R) (L) (B) (IMPLANTS)* TECH KATHY