

PATIENT NAME _____ AGE _____ DATE OF BIRTH _____

TODAY'S DATE: _____

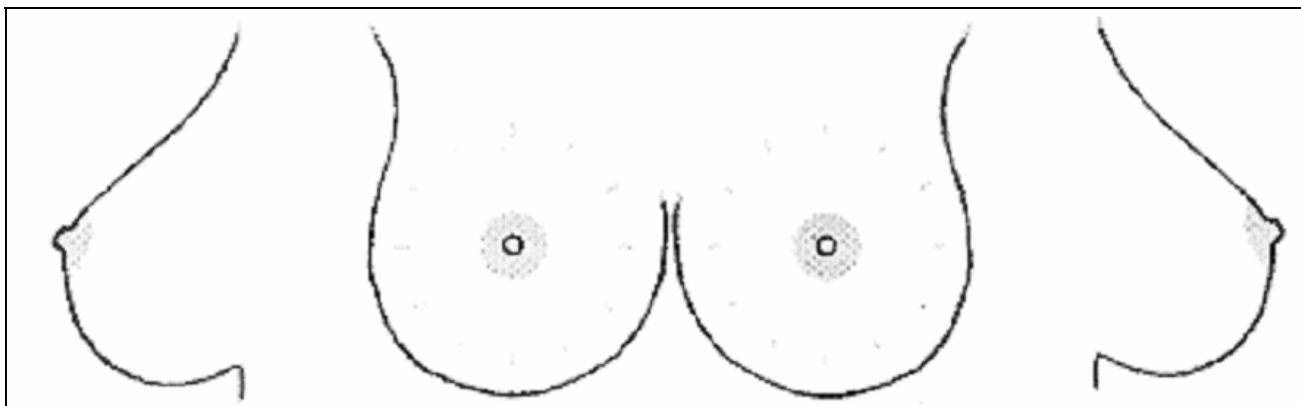
QUESTIONS

1. PREVIOUS MAMMOGRAM ? WHEN _____ WHERE _____
2. PREVIOUS **BREAST** ULTRASOUND? WHEN _____ WHERE _____
3. DO YOU HAVE A FAMILY HISTORY OF BREAST CANCER? ____ WHO _____
4. HAVE YOU EVER HAD BREAST CANCER? _____
5. HAVE YOU STARTED/STOPPED HORMONE THERAPY (BIRTH CONTROL)
DATE: _____
6. DO YOU HAVE ANY **NEW** BREAST PROBLEMS? PLEASE DESCRIBE

7. HAVE YOU HAD ANY BREAST SURGERY , SUCH AS : (PLEASE INDICATE R=RIGHT, L=LEFT,AGE WHEN THIS OCCURRED IF KNOWN AND DATE OF PROCEDURE)

- BIOPSY R ____ L ____ DATE: _____
- CYST ASPIRATION R ____ L ____ DATE: _____
- IMPLANTS (SILICONE OR SALINE)
- LUMPECTOMY, RADIATION _____ CHEMOTHERAPY _____
R ____ L ____ DATE: _____
- MASTECTOMY, RADIATION _____ CHEMOTHERAPY _____
R ____ L ____ DATE: _____
- OTHER _____

OFFICE USE ONLY



TECHNOLOGISTS

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