PREMIER WOMEN'S RADIOLOGY

Patient Name: _____ **Date of Birth:** _____

Referring Physician: _____

Have you ever had a mammogram before? ☐ Yes ☐ No

Where: _____ When: _____

Last breast exam by a doctor: _____

Have you had a breast ultrasound and/or MRI before? ☐ Yes ☐ No Date(s): _____

REASON FOR VISIT

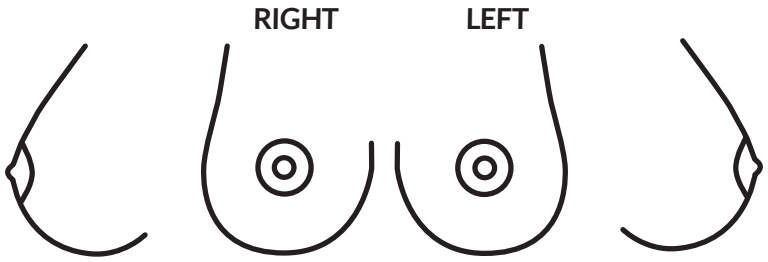
☐ Routine ☐ Call back (Add'l eval) ☐ Short term follow up ☐ Problem indicated ☐ Review of outside study ☐ Other: _____

PROBLEM

		How long?	Comment
Lump or thickening	☐ R ☐ L		
Non-bloody discharge	☐ R ☐ L		
Bloody discharge	☐ R ☐ L		
Skin thickening or retraction	☐ R ☐ L		
Pain	☐ R ☐ L		
Nipple abnormality	☐ R ☐ L		
Other: _____	☐ R ☐ L		

HISTORY

		How long?	Comment
Mastectomy	☐ R ☐ L		
Lumpectomy (for cancer)	☐ R ☐ L		
Radiation	☐ R ☐ L		
Implant	☐ R ☐ L		
Breast reduction	☐ R ☐ L		
Benign surgical biopsy	☐ R ☐ L		
Benign core biopsy	☐ R ☐ L		
Cysts aspiration	☐ R ☐ L		
Other: _____	☐ R ☐ L		



☐ Yes ☐ No Family history of breast cancer?

☐ Mother, age_____ ☐ Sister, age _____ ☐ Aunt (M/P), age_____ ☐ Daughter, age _____

☐ Grandmother (M/P), age _____ ☐ Father, age _____ ☐ Cousin, age_____

☐ Yes ☐ No Do you still have menstrual periods? LMP _____

Age of first menstruation_____

☐ Yes ☐ No Are you pregnant or have you breast fed in the last four months?

☐ Yes ☐ No Have you had a child? Age at first child's birth_____

☐ Yes ☐ No Have you had a weight change of more than 10lbs. in the last year?

☐ Yes ☐ No Have you taken any hormone medication? Duration _____

Type: ☐ estrogen ☐ progesterone ☐ birth control pills ☐ other

☐ Yes ☐ No BRCA tested? If tested, BRCA positive? ☐ Yes ☐ No

☐ Yes ☐ No Any personal or family history of ovarian cancer? Who _____

Signature of Patient: _____ **Date:** _____