History Form

BREAST HISTORY

Name: _____ Age: _____ Date: _____

Referring Doctor: _____ Imaging Center: _____

Reason for this examination: _____

Have you had a Mammogram / Ultrasound before? ☐ Yes ☐ No When? _____ Where? _____

Have you ever had a Breast MRI before? . . . . . ☐ Yes ☐ No When? _____ Where? _____

PHYSICAL CONCERNS			Right	Left	How Long?
Do you feel a lump?	☐ Yes	☐ No			
Is this a new finding?	☐ Yes	☐ No			
Focal or specific point of pain?.	☐ Yes	☐ No			
Have you had recent trauma to a breast?	☐ Yes	☐ No			
Nipple discharge or retraction?	☐ Yes	☐ No			
Skin dimpling?	☐ Yes	☐ No			

Additional Information: _____

BREAST SURGICAL HISTORY			Right	Left	Month / Year
Previous Breast Cancer	☐ Yes	☐ No			
Mastectomy	☐ Yes	☐ No			
Lumpectomy (cancer)	☐ Yes	☐ No			
Radiation Therapy	☐ Yes	☐ No			
Chemotherapy	☐ Yes	☐ No			
Biopsy (Needle or Surgical)	☐ Yes	☐ No			
Needle Aspiration	☐ Yes	☐ No			
Reconstruction / Reduction	☐ Yes	☐ No			
Implants or Silicone Injections	☐ Yes	☐ No			

Additional Information: _____

GENERAL HISTORY

Are you pregnant?. . . . . ☐ Yes ☐ No
Breast fed within last 4-6 months?. . . . . ☐ Yes ☐ No
Any family history of breast cancer?. . . . ☐ Yes ☐ No
Which relative and age? _____
Have you had any other type of cancer? ☐ Yes ☐ No
If yes, what kind? _____
Age at your first full term pregnancy? _____ Years

MENSTRUAL HISTORY

1st day of your last period: _____
Menopause?. . . . ☐ Yes ☐ No
Hysterectomy?. . . ☐ Yes ☐ No
Are you taking hormones or birth control pills? ☐ Yes ☐ No
If yes, what kind? _____
If yes, how long? _____

Additional Information: _____

OFFICE USE ONLY
Clinical Findings

Clinical indications/Notes:

_____
_____
_____
_____

Technologist's Name: _____

1. On review of your screening mammogram, if an area needs further evaluation, we will contact you to schedule an appointment. (There is an additional charge for these views).
2. If an ultrasound exam is recommended, this is considered a separate study and is billed separately.
3. In the event that additional views and/or breast ultrasound is performed on the same day as your screening mammogram, be aware that there is an additional charge for these exams.

PLEASE BE ADVISED THAT A DIAGNOSTIC MAMMOGRAM AND/OR BREAST ULTRASOUND ARE NOT CONSIDERED TO BE A ROUTINE PREVENTATIVE EXAM AND MAY INCUR ADDITIONAL OUT OF POCKET EXPENSE.

To the best of my knowledge, all of the above is true and correct.

Patient Signature: _____ Date: _____