MAMMOGRAPHY PATIENT HISTORY

Last Name First Name Date of Birth

Have you had a previous mammogram? Yes No
When?
Where?

Are you or could you be pregnant? Yes No

WHAT IS THE REASON YOU ARE HAVING A BREAST IMAGING EXAM? (SELECT ONE)

This is a routine screening exam. I am not having any breast problems.
This is a short interval follow up exam, requested after my last exam (1 to 11 months ago).
I have a problem that is explained in the box below.
I am going to have a breast reduction.
I am going to have radiation therapy.
This is an additional exam requested from my current exam.

I AM HAVING THE FOLLOWING PROBLEM(S): PLEASE NOTE RIGHT AND OR LEFT BREAST

R **L** A New Lump Can Be Felt
R **L** Bloody Discharge
R **L** Non-Bloody Discharge
R **L** Implant Problem
R **L** Large Nodes Under Arm
None Of The Above
Cancer Elsewhere Explain:

R **L** Other Lump Or Thickening
R **L** Nipple Problem
R **L** Pain In Breast
R **L** Difficult Physical Exam

DO YOU HAVE IMPLANT(S)? PLEASE NOTE RIGHT AND OR LEFT BREAST

R **L** Silicon Gel Implant
R **L** Saline Implant
R **L** Combination Implant
R **L** Implant Revision Or Removal

R **L** Pre-Pectoral Implant (In Front Of Muscle)
R **L** Retro-Pectoral Implant (Behind Muscle)
R **L** Silicone Injections
R **L** I don't Know The Specific Type Of Implant

HAVE YOU HAD ANY OF THE FOLLOWING PROCEDURES? PLEASE NOTE RIGHT AND OR LEFT BREAST

R **L** Mastecomy
R **L** Excisional Biopsy
R **L** Stereotactic Core Biopsy
R **L** Cyst Aspiration
R **L** Lumpectomy for Cancer

R **L** Implant Removed
R **L** Radiation Therapy
R **L** Breast Reduction
R **L** FNA (Fine Needle Aspiration)

Have you ever had Chemotherapy? Yes No If yes, date of Chemotherapy:
If yes, for what type of cancer?
If breast cancer, which breast? Right Left Both

Have you ever had Radiation Therapy? Yes No If yes, date of Radiation Therapy:
If yes, for what type of cancer?
If breast cancer, which breast? Right Left Both

ARE YOU USING ANY OF THE FOLLOWING HORMONES?

Birth Control Yes No
Progesterone Yes No
Other:

Estrogen Yes No
Tamoxifen Yes No

Have you had a hysterectomy? Yes No At what age?

SKIN ABNORMALITIES PLEASE NOTE RIGHT AND OR LEFT BREAST

R **L** Moles
R **L** Other:

R **L** Scars

inview Imaging
BRAD M. PIATT, MD & ASSOCIATES

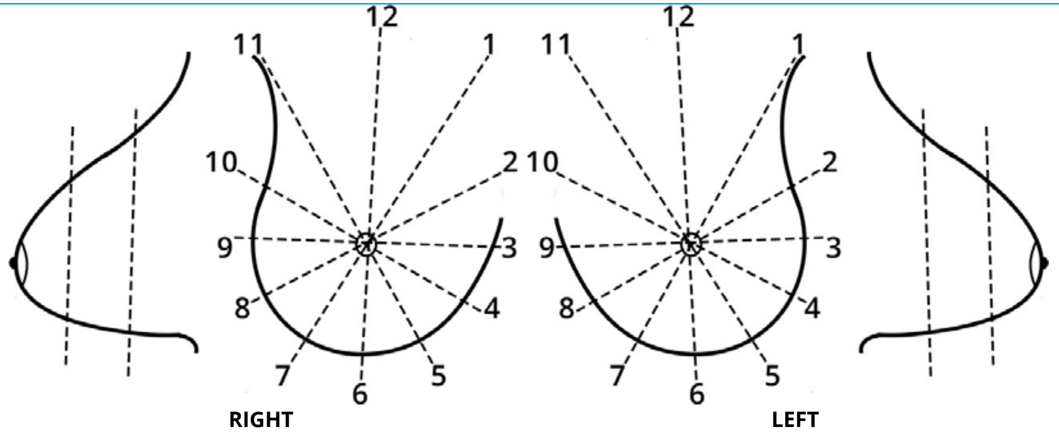
MAMMOGRAPHY PATIENT HISTORY CONTINUED

RISK FACTORS: CHECK ALL THAT ARE TRUE FOR YOU

No one in my family has had breast cancer.
I have had breast cancer.
Members of my family have had breast cancer. Check Which Relative(s)
Sister Mother Aunt Grandmother Other: ____________
When diagnosed was she or were they Pre-Menopausal? (Less than 50 Years Old) Yes No
When diagnosed was she or were they Post-Menopausal? (More than 50 Years Old) Yes No
I have undergone genetic testing which determined the presence of the BRCA1 and or BRCA2 gene. Check Below
BRCA1 BRCA2
I do not know my family breast cancer history.
I have had a previous breast biopsy that showed a high-risk lesion.
I had my first child after age 30.

On the diagram, mark the location of previous biopsies, lumpectomies, or where you feel a lump or thickening.

Please explain in the notes below what your markings indicate.



Notes:

PATIENT'S SIGNATURE ____________________________________ DATE ______________