635 Madison Avenue, 16th Fl
New York, NY 10022

MEDICAL IMAGING OF MANHATTAN, LLC

Acc #: Tech: _____ Date of Study:

BREAST IMAGING WORKSHEET (Female)

Patient: Age: Date of Birth:

DATE OF LAST EXAMS, IF NOT DONE HERE:

MAMMOGRAM: _____ BREAST SONOGRAM: _____ BREAST MRI: _____

WHERE WAS IT DONE? _____

ARE YOU PREGNANT? ❑ YES ❑ NO

❑ What is the reason for having this breast exam?
❑ This is a routine exam. I AM NOT HAVING ANY BREAST PROBLEMS.
❑ This is a short interval follow-up requested from my last exam (1-11 months ago).

❑ New lump that can be felt	R ❑ L ❑	❑ Skin changes	R ❑ L ❑
❑ Other NEW thickening	R ❑ L ❑	❑ Nipple problem	R ❑ L ❑
❑ Large nodes under my arm	R ❑ L ❑	❑ Other	R ❑ L ❑

❑ Bloody or clear spontaneous nipple discharge R ❑ L ❑

DATE OF LAST BREAST PHYSICAL EXAM PERFORMED BY YOUR PHYSICIAN _____
❑NORMAL
❑ABNORMAL ❑ R ❑ L

Please indicate if you ever had any of the following procedures:

			DATE(S)
Implants	R ❑ L ❑	❑Saline ❑Silicone	_____
Breast reduction	R ❑ L ❑		_____
Mastopexy (breast lift)	R ❑ L ❑		_____
Cyst aspiration	R ❑ L ❑		_____
Needle biopsy	R ❑ L ❑	❑atypical hyperplasia ❑ LCIS	_____
Excision biopsy	R ❑ L ❑	❑atypical hyperplasia ❑ LCIS	_____
Lumpectomy for cancer	R ❑ L ❑		_____
Mastectomy	R ❑ L ❑		_____
Reconstruction	R ❑ L ❑		_____
Pacemaker	R ❑ L ❑		_____
Chemo port	R ❑ L ❑		_____
Radiation Therapy	R ❑ L ❑		_____

Other: _____

Please enter your menstrual history (where applicable):

Age when periods started _____ Have you given birth to any children? ❑ YES ❑ NO
If yes, age at first term pregnancy _____

Age at menopause (if applicable) _____
Were you ovaries removed? ❑ YES ❑ NO Last menstrual period _____

Please list if you regularly take any of the following:

1) Any product that contains estrogen or progesterone (hormone replacement therapy, birth control, other) _____
2) Tamoxifen/Arimidex/chemotherapy _____
3) Evista _____
4) All other prescription medications _____
5) Aspirin, Advil, or other anti-inflammatories _____

IMPORTANT: Check the following THAT ARE TRUE FOR YOU:
❑ No one in my family has had breast cancer.

❑Mother	Age at diagnosis: _____	Number of breasts involved: _____
❑Father	Age at diagnosis: _____	Number of breasts involved: _____
❑Sister(s)	Age at diagnosis: _____	Number of breasts involved: _____
❑Brother(s)	Age at diagnosis: _____	Number of breasts involved: _____
❑Daughter(s)	Age at diagnosis: _____	Number of breasts involved: _____
❑Son(s)	Age at diagnosis: _____	Number of breasts involved: _____

❑Grandmother(s)	❑Maternal	❑Paternal	Age at diagnosis: _____	Number of breasts involved: _____
❑Grandfather(s)	❑Maternal	❑Paternal	Age at diagnosis: _____	Number of breasts involved: _____
❑Aunt(s)	❑Maternal	❑Paternal	Age at diagnosis: _____	Number of breasts involved: _____
❑Uncle(s)	❑Maternal	❑Paternal	Age at diagnosis: _____	Number of breasts involved: _____

❑I have had breast cancer ❑ R ❑ L Age at each diagnosis:
❑I have had ovarian cancer. Age at diagnosis:
❑My close family member has had ovarian cancer. Relation(s):
❑I (or a close family member) have been tested for the BRCA genetic mutations:

❑ BRCA-1	❑ BRCA-2	❑ positive	❑ negative	Relation: _____
❑ BRCA-1	❑ BRCA-2	❑ positive	❑ negative	Relation: _____
❑ BRCA-1	❑ BRCA-2	❑ positive	❑ negative	Relation: _____

❑List any serious medical conditions: _____

_____

Do you wish for your report to be sent to any additional physicians:

1. _____
2. _____
3. _____

Patient: Acc #: DOS: