# Breast History Form

Name: ______ Age: ______ Date of Exam: ______

Referring Doctor: ______ Imaging Center: ______

Why are you having this exam? ______

List any symptoms, issues, area of concern, and how long: ______

Prior Mammogram or Ultrasound? ☐ Yes ☐ No When? ______ Where? ______

Prior Breast MRI? . . . . . . . . . . . . ☐ 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 | | | |
| Tissue Expander | ☐ Yes | ☐ No | | | |

Additional Information: ______

## GENERAL HISTORY

Are you pregnant? . . . . . . . . . . . . ☐ Yes ☐ No

Breast fed within last 4-6 months? ☐ Yes ☐ No

A family history of breast cancer? ☐ Yes ☐ No

Which relative and age? ______

Have you had any other 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? ☐ Yes ☐ No

If yes, what kind? ______

If yes, how long? ______

Enter any additional information below:

## NOTE

1. If a screening mammogram needs further evaluation, we will contact you to schedule an appointment. There is an additional charge for these views, even if they are performed the same day as a screening mammogram.
2. If an ultrasound exam is recommended, this is considered a separate study and it is billed separately.
3. Please be advised that diagnostic mammograms and breast ultrasounds are not considered to be preventative exams and may incur additional out of pocket expense.

**Patient Signature:** ______ Date: ______

## FOR OFFICE USE ONLY

**Clinical Indications/Notes:**