

**Known Patient Data**

Today's Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_ Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Henderson & Walton Dr.: \_\_\_\_\_ Date of Visit: \_\_\_\_\_

**Last Mammogram Exam:** \_\_\_\_\_ **Facility Name:** \_\_\_\_\_

**Under what name?** \_\_\_\_\_ **Physician at that time?** \_\_\_\_\_

**Date of Last Period** \_\_\_\_\_ **Last M.D. Breast Exam:** \_\_\_\_\_

- Please sign below to document that you are not pregnant.
- I authorize obtaining or releasing my breast health records for comparison and follow-up.

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Known Referring Doctor**

**Reason for Today's Exam:**

Routine Screening: \_\_\_\_\_ Baseline \_\_\_\_\_ Follow-up \_\_\_\_\_

Lump: No \_\_\_\_\_ Yes \_\_\_\_\_ R L B When noticed? \_\_\_\_\_

Describe: \_\_\_\_\_

Nipple Discharge: No \_\_\_\_\_ Yes \_\_\_\_\_ R L B Color? \_\_\_\_\_

**Known Medical History**

**History:**

\_\_\_\_\_ Personal history of breast cancer - Age \_\_\_\_\_

Hysterectomy: No \_\_\_\_\_ Yes \_\_\_\_\_ When: \_\_\_\_\_ (Age or Year)

Hormones: No \_\_\_\_\_ Yes \_\_\_\_\_ When: \_\_\_\_\_ (Age or Year)

**Family History of Breast Cancer - check those that apply**

\_\_\_\_\_ Aunt \_\_\_\_\_ Grandmother \_\_\_\_\_ Cousin

\_\_\_\_\_ Mother \_\_\_\_\_ Sister \_\_\_\_\_ Daughter

\_\_\_\_\_ Pre-menopausal \_\_\_\_\_ Post-menopausal \_\_\_\_\_

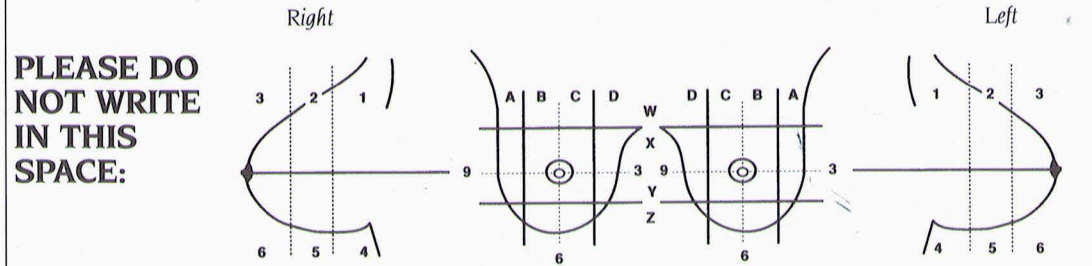
**Known Risk Factors**

**Prior Breast Procedures:**

*Please indicate year done & which breast.*

Implants _____ R L B	<b>If previous breast cancer:</b>
Reduction _____ R L B	Mastectomy _____ R L B
Biopsy (excisional) _____ R L B	Lumpectomy _____ R L B
Biopsy (needle) _____ R L B	Chemotherapy _____ R L B
Stereotactic Biopsy _____ R L B	Radiation _____ R L B
Aspiration _____ R L B	

**Previous Procedures**



**Notes**

**Tech Initials:** \_\_\_\_\_