DIAGNOSTIC IMAGING CENTERS, P.A.

Breast Imaging Exam Form

Tech Initials: _____

MRN #: _____

PATIENT INFORMATION

Name: _____ Date of Birth: _____ Age: _____ Date of last mammogram: _____

Reason for today's exam: ❑ First mammogram ever ❑ Annual mammogram

New symptoms may require Doctor's order ❑ New symptom/problem ❑ 6-month follow-up

*Describe your *new* breast problem and how long you have had it (if applicable): _____

_____

MEDICAL INFORMATION AND RISK ASSESSMENT

FAMILY HISTORY

1. Has anyone in your **Family** been diagnosed with **breast** cancer?	❑ Yes ❑ No
✓ If *Yes* , please check the relative and age at time of diagnosis:	❑ Mother/Age____ ❑ Daughter/age____ ❑ Sister/age___ ❑ Aunt/Age____ → ❑ Maternal ❑ Paternal ❑ Grandmother/Age____ → ❑ Maternal ❑ Paternal

PERSONAL HISTORY

1. Race:	❑ White ❑ African American ❑ Hispanic ❑ Unknown ❑ Asian-American ❑ American Indian/Alaskan Native
2. Ethnicity (If applicable):	❑ Chinese ❑ Japanese ❑ Filipino ❑ Hawaiian ❑ Other Pacific Islander ❑ Other Asian-American
3. Have *you* previously been diagnosed with **breast** cancer?	❑ Yes ❑ No
4. Do *you* have a history of **female** cancer? *(Ovarian, uterine, cervical)*	❑ Yes ❑ No
5. Known BRCA1 or BRCA2 mutation or similar genetic syndrome?	❑ Yes ❑ No
6. Do you take hormones?	❑ Yes ❑ No
✓ If *Yes* , please check the ones you are currently using: Length of time on hormones: _____ ❑ Months ❑ Years	❑ Birth control ❑ Estrogen ❑ Progesterone ❑ Tamoxifen ❑ Evista ❑ Arimidex
7. Age at *first* menstrual period?	❑ Age 7-11 ❑ Age 12-13 ❑ Age 14 or older
8. Date of your *last* menstrual period: _____	
9. Are you **post menopausal?**	❑ Yes ❑ No
10. Are you pregnant?	❑ Yes ❑ No
11. Age when you had your first child?	❑ No Births ❑ Under 20 ❑ Age 20-24 ❑ Age 25-29 ❑ Age 30 + ❑ Unknown

BREAST PROCEDURES

1. History of breast biopsy?	❑ Yes ❑ No ❑ Rt ❑ Lt Date(s):_____
✓ If *Yes* , how many times?	❑ 1 ❑ More than 1
Did any of the biopsies show *atypical* hyperplasia? *(or other high risk marker on biopsy?)*	❑ Yes ❑ No
2. History of mastectomy?	❑ Yes ❑ No ❑ Rt ❑ Lt ❑ Bilateral Date: _____
3. History of lumpectomy?	❑ Yes ❑ No ❑ Rt ❑ Lt ❑ Bilateral Date: _____
4. Treatment:	❑ Chemotherapy ❑ *with* radiation ❑ *without* radiation
5. History of breast reduction surgery?	❑ Yes ❑ No Date: _____
6. History of breast implant surgery?	❑ Yes ❑ No Date: _____

Patient Signature: _____ Date: _____