Breast Imaging Patient History

Patient Name: (first & last) _____ **Date:** _____

Date of Birth: _____ **Phone #:**_____ **Ordering Physician:** _____ ☐ **N/A**

Circle No or Yes:

No Yes 1. Have you had a previous mammogram?
If Yes: When? _____
Where? _____

No Yes 2. Have you had a previous Breast MRI or Breast Ultrasound?
If Yes: When? _____
Where? _____

No Yes 3. Are you having any *NEW* areas of pain in your breast(s)?

No Yes 4. Have you or your doctor recently found a *NEW* lump or mass in your breast(s)?

No Yes 5. Are you having any *NEW* nipple discharge or *NEW* puckering of the skin or nipple?

No Yes 6. Have you had any prior breast surgery?
If Yes: **circle:**
___Biopsy: Right /Left Date: _____
___Aspiration: Right /Left Date: _____
___Reduction Date: _____
___Implants Date: _____
___Other_____

No Yes 7. Do you have a history of breast cancer?
If Yes: Location (circle): Right Left Both
___Mastectomy Date: _____
___Lumpectomy Date: _____
___Chemotherapy # of Treatments_____
___Radiation # of Treatments:_____

No Yes 8. Do you have a family history of breast cancer?
If Yes:
___Mother Age diagnosed: _____
___Sister Age diagnosed: _____
___Daughter Age diagnosed: _____
___Other_____

No Yes 9. Are you taking any hormone replacements?

No Yes 10. Is there any possibility you may be pregnant?

11. What is the date of your last menstrual period?
Estimated Date: _____

TO ALL MAMMOGRAPHY PATIENTS: I understand that:

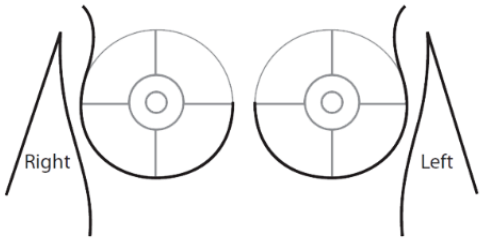
- Mammograms do not detect all breast cancers. They must be combined with periodic physical exam, monthly breast self-exam, and comparison with any prior mammograms.
- Any time I develop a new breast problem OR if I am having any new breast problems now, it is my responsibility to report this to my physician, and also to the technologist at the time of my mammogram.
- If I have been scheduled for a screening mammogram but have a ***new*** breast problem, I may need to have a diagnostic mammogram and/or breast ultrasound, which my physician will need to order.
- If my physician has ordered this test, I must contact my physician for my final mammogram results. If this was a self-referred screening mammogram exam, I understand I will receive my screening mammogram results in the mail, at the address I provided.

_____ _____ _____ _____
Date **Time** **Patient Signature** **Print Name**

_____ _____ _____ _____ _____
Date **Time** **Legally Authorized Person/ Care Giver Completing form Signature** **Print Name** **Relationship**

_____ _____ _____
Interpreter Name **ID Number** **Language Interpreted**

FOR TECHNOLOGIST USE ONLY: **Technologist Comments:** _____



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☐ EMR ☐ PHYSICIAN SCRIPT ☐ SELF-REFERRED

_____ _____ _____ _____
Date **Time** **Technologist Authentication** **Print Name**

Patient Label or
Patient Name_____
MRN_____

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#930090 Revised 7/16/2015 kcg714

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