

the Breast Center at IMAGECARE

NAME: _____ DATE OF BIRTH: _____
 LAST PHYSICAL BREAST EXAM IN PHYSICIANS OFFICE _____ MONTH _____ YEAR

WOULD YOU LIKE A CHAPERONE? YES NO

REASON FOR TODAY'S EXAM: Screening: _____
 Short Interval Follow-up: _____
 Having a problem? (Please describe) _____
 Other (Please describe): _____

FAMILY HISTORY OF BREAST CANCER: YES NO
 (Please indicate relative and age) Mother ____ Sister ____ Daughter ____ Father ____
 Grandmother (Paternal/Maternal) ____ Aunt ____

PERSONAL HISTORY:

Previous Mammo (Where and When?): _____
 Personal History of Breast Cancer/Ovarian Cancer (Include Age Diagnosed): _____

Chemotherapy: _____ Radiation Therapy: _____

BREAST SUGERIES: YES NO Cancerous?: Yes No
 Mastectomy: Which Breast? L R Year: _____ Check: **R for Right**
 Lumpectomy: cancer Which Breast? L R Year: _____ **L for Left**
 Implants Which Breast? L R Year: _____ Type: _____

***Implant patients-With Compression there is a small chance that rupture could occur _____ / _____

Benign Surgery Which Breast? L R Year: _____ Reason: _____
 Significant Weight Change Gain Loss
 Breast Augmentation/Reduction Year: _____

MENSTRUAL HISTORY:

Are you currently pregnant? YES NO
 Number of pregnancies? _____

Age of first period: _____
 Hysterectomy: Yes No Year: _____

Ovaries Removed: Yes No Year: _____

MEDICATIONS:

- Hormone(s) Type: _____
 How Long? _____
- Thyroid Medication: _____
- Anti-Depressants _____
- _____
- _____
- Tamoxifen _____
- Blood Pressure Med _____
- Heart Medication _____
- Other: _____