

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 Mammogram (Where and When?): _____
 Personal History Of Breast Cancer (Include Age Diagnosed): _____
 Personal History Of Other Cancer (Please explain): YES NO _____
 Chemotherapy: _____ Radiation Therapy: _____

BREAST SURGERIES: YES NO Cancerous? Yes No

<input type="checkbox"/> Mastectomy:	Which breast? <input type="checkbox"/> L <input type="checkbox"/> R	Year: _____	
<input type="checkbox"/> Lumpectomy:cancer	Which breast? <input type="checkbox"/> L <input type="checkbox"/> R	Year: _____	
<input type="checkbox"/> Implants	Which breast? <input type="checkbox"/> L <input type="checkbox"/> R	Year: _____	Type: _____
<input type="checkbox"/> Benign Surgery	Which breast? <input type="checkbox"/> L <input type="checkbox"/> R	Year: _____	Reason: _____

MEDICATIONS:

Hormone(s) Type: _____
 How long? _____
 Thyroid Meds: _____
 Anti-depressants _____

 Blood Pressure Med _____
 Heart Medication _____
 Other: _____

