BREAST HISTORY

Office Use Only:
Gail Score
5 YR Risk:_____
Lifetime Risk:_____

Name: _____

Date of birth: _____ Age: _____ Referring Physician: _____

RACE/ETHNICITY
- □ White
- □ African American
- □ Ashkenazi Jewish Heritage
- □ American Indian or AK Native
- □ Asian or Pacific Islander
- □ Unknown
- □ Hispanic

CURRENT BREAST PROBLEMS
- □ **NONE**
- □ Lump □ Right □ Left
- □ Tenderness/Pain □ Right □ Left
- □ Nipple Secretion □ Right □ Left
  Color _____

PERSONAL HISTORY
Are you pregnant? □ Yes □ No
Last clinical breast exam: _____
Date of last menstrual period: _____
Age of first period: _____
Age of first pregnancy: _____
Number of births: _____
Are you currently using hormones □ Yes □ No
Are you currently using contraceptives □ Yes □ No
History of Hodgkin's Lymphoma □ Yes □ No
If yes, radiation treatment □ Yes □ No
Age diagnosed _____

PREVIOUS MAMMOGRAMS
□ **NONE**
Date of last mammogram: _____
Where performed: _____

BREAST IMPLANTS □ Yes □ No

PREVIOUS GAMMAGRAM OR BREAST MRI
□ **NONE**
Date of last GAMMA or breast MRI: _____
Where performed: _____

RISK FACTORS
If adopted do you know natural family history? □ Yes □ No □ N/A
Have you had breast or ovarian cancer? □ Yes □ No If yes, specify: _____

Family history of breast and/or ovarian cancer ONLY :

□ NONE	Current Age or Age Deceased	Age Diagnosed	Breast Cancer	Ovarian Cancer	Deceased		Current Age or Age Deceased	Age Diagnosed	Breast Cancer	Deceased
□ Mother			□	□	□	□ Father			□	□
□ Sister			□	□	□	□ Brother			□	□
□ Daughter			□	□	□	□ Son			□	□
□ Grandmother			□	□	□	□ Grandfather			□	□
□ Aunt			□	□	□	□ Uncle			□	□
□ Cousin (1st Degree)			□	□	□					

Have you or a family member been tested for the breast cancer gene (BRCA 1 or BRCA2)? □ Yes □ No

BREAST SURGERY OR BIOPSY
□ **NONE**

				Positive	Negative
□ Biopsy	□ Right	□ Left	Date _____	□	□
□ Lumpectomy (benign)	□ Right	□ Left	Date _____	□	□
□ Lumpectomy (cancer)	□ Right	□ Left	Date _____	□	
□ Lumpectomy (w/radiation)	□ Right	□ Left	Date _____	□	
□ Mastectomy	□ Right	□ Left	Date _____		
□ Reduction	□ Right	□ Left	Date _____		

_____ _____
PATIENT SIGNATURE **DATE**

Technologist: _____

(Revised 2/19/14)