NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Your Age: \_\_\_\_\_\_\_\_

 The date your doctor / nurse last examined your breasts: \_\_\_\_\_\_\_\_\_\_\_\_

Have you had a previous mammogram?  YES  NO If yes: When? \_\_\_\_\_\_\_\_\_ Where? \_\_\_\_\_\_\_\_

***REASONS FOR TODAY'S EXAMINATION***

|  |  |
| --- | --- |
|  Routine |  RIGHT  LEFT  |
|  I Feel Something |  RIGHT  LEFT  |
|  My Doctor Feels Something |  RIGHT  LEFT  |
|  Nipple Discharge |  RIGHT  LEFT  |
|  Pain |  RIGHT  LEFT  |
| Other  |

Right

Left

If something is felt, please mark it on diagram

 ***Gail Score Questions***

**Do you have a medical history of Breast Cancer?**  YES  NO **DCIS** **LCIS**

**History of atypical hyperplasia**  YES  NO

**Age at first MENSTRUAL period?** \_\_\_\_\_\_\_\_  **Age at first live BIRTH of CHILD?** \_\_\_\_\_\_\_\_

 Have any of the following been diagnosed with ***breast cancer***?  YES  NO

** Self  Mother  Father  Sister  Daughter**  if so, at what approx. Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Breast History***

|  |  |
| --- | --- |
| **A Cyst drained** | Right Left When: |
| **Biopsy, Benign** | Right Left When: How many? |
| ** Biopsy, Cancer** | Right Left  When: |
| **Trauma** | Right Left When: |
| **Implants** | Right Left When: |
| **Breast Reduction** | Right Left When: |
| **Other:**  |  |

 **Have you ever had? (if so, please indicate when)**

***ETHNICITY:*  Caucasian (white)  African-American  Hispanic  Asian Other\_\_\_\_**

**Have you ever had? BREAST CANCER TREATMENT**

|  |  |  |
| --- | --- | --- |
| a mastectomy? |  YES  NO  | If yes, which side? RIGHT LEFT |
| breast reconstruction? |  YES  NO  | If yes, which side? RIGHT LEFT |
| radiation therapy to your breast(s)? |  YES  NO  | If yes, which side? RIGHT LEFT |
| chemotherapy |  YES  NO |  |
| a lumpectomy |  YES  NO | If yes, which side? RIGHT LEFT |

***Hormone Use***

Have you ever used female hormones, such as estrogen **including** birth control? YES  NO

 If so, are you presently using them and for how long?  YES  NO Years \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize Capital Imaging Associates to obtain any follow up results from my physician if needed. I understand this is being done to help maintain Capital Imaging Associates’ accreditation by the American College of Radiology and the Federal Mammography Quality Standard Act of '92 (MQSA)

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_