the Breast Center at IMAGECARE

NAME: _____ DATE OF BIRTH: _____

LAST PHYSICAL BREAST EXAM IN PHYSICIANS OFFICE: MONTH _____ YEAR _____

REASON FOR TODAY'S EXAM: ☐Having a problem? (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 (Include Age Diagnosed): _____

_____

☐ Chemotherapy: _____ ☐ Radiation Therapy: _____

BREAST SURGERIES: ☐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: _____
☐ 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: _____

_____