the Breast Center at IMAGECARE

NAME: ________________ ________________________ DATE OF BIRTH: ______________________________
LAST PHYSICAL BREAST EXAM IN PHYSICIANS OFFICE ____________________MONTH ______________ YEAR

REASON FOR TODAY'S EXAM:

☐ Screening: ____

☐ Short Interval Follow-up: ____

☐ Having a problem? (Please describe) ____________________________________

☐ Other (Please describe): ____

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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? ____

☐ Chemotherapy: ______________________________ ☐ Radiation Therapy: ____________________________

BREAST SURGERIES: ☐ YES ☐NO Cancerous? Yes ☐ No ☐

☐ Mastectomy:	Which Breast?	☐L	☐R	Year: ____	Check: **R** for Right **L** for Left
☐ Lumpectomy: cancer	Which Breast?	☐L	☐R	Year: ____	
☐ Implants	Which Breast?	☐L	☐R	Year: ____	Type: ____________________
☐ Benign Surgery	Which Breast?	☐L	☐R	Year: ____	Reason: ____________________

MEDICATIONS:
☐ Hormone (s) Type: __________
How Long? ___________
☐Thyroid Medication: _________
☐Anti-Depressants ____________
☐Blood Pressure Med __________
☐Heart Medication ____________
☐Other: ___________________
☐______________________
☐______________________
☐______________________
☐______________________