

**For Patient to Complete**

Patient Name: _____	Age: _____	Soc. Sec. #: _____
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Referring Physician: \_\_\_\_\_

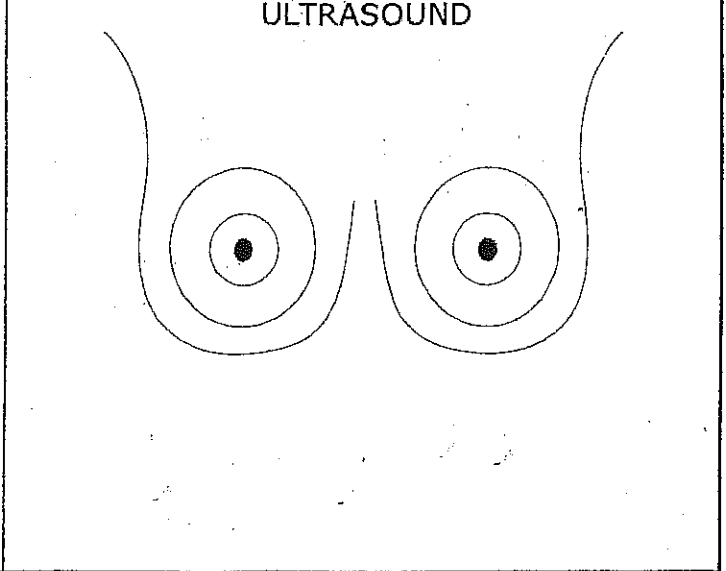
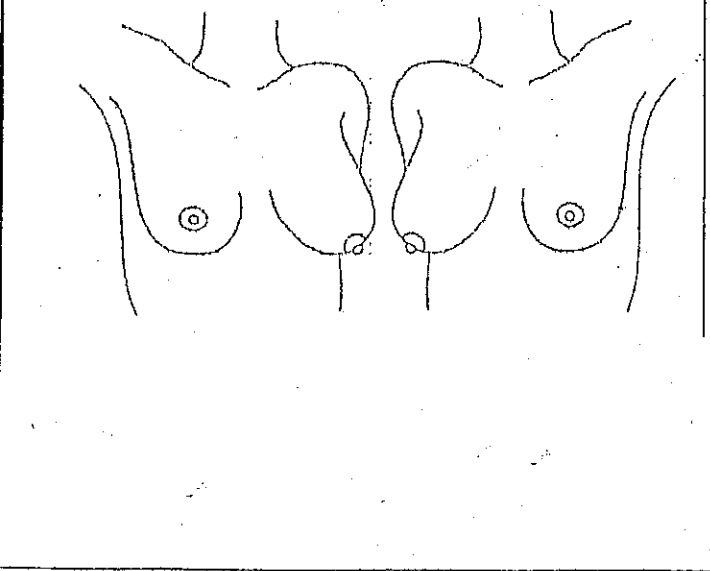
Other Physicians: \_\_\_\_\_

Yes	No	Question (Please place check mark ✓ in appropriate column.)
		Have you had previous mammograms? If so, where? _____ When? _____
		Are you having any problems with either breast? If so, please explain: _____
		Have you had recent breast physical examination? By whom? _____ When? _____
		Is there breast cancer in your family? Mother at age _____. Sister at age _____. 2 <sup>nd</sup> Sister at age _____. Other: _____
		Are you taking hormones? For how long? Please list: _____
		Have you ever taken Tamoxifen or Arimidex? For how long? _____
		Today, did you use body powder, lotion or deodorant? _____
		Is there any chance that you may be pregnant? _____
		Do you perform monthly breast exam? _____

**Patient Signature:** \_\_\_\_\_

**For Facility Use Only**

<b>At present:</b>				<b>In the past:</b>					
<input type="checkbox"/> Doesn't have any problems.				<input type="checkbox"/> Has had no procedures.					
Pt. Has:	Side		O'clock	Duration	Pt. has had:	Side		When	Diagnosis
Lump	R	L			Mastectomy	R	L		
Tenderness, pain	R	L			Lumpectomy	R	L		
	<input type="checkbox"/> Diffuse <input type="checkbox"/> Focal:				(cancer)	R	L		
Thickening	R	L			Surgical biopsy	R	L		
Discharge	R	L			Core needle biopsy	R	L		
N.retraction	R	L			Cyst aspiration	R	L		
Skin retrxn	R	L			Radiation therapy	R	L		
Other:					Implants	R	L		
					Reduction	R	L		
				Chemotherapy					



Tech: _____	# views: _____	Tech Initials: _____	11/9/2006
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