Last name: _ First: _ MI _ _ _ _ _

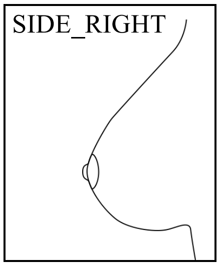
Street :_ City: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ State:_ _ _ _ _

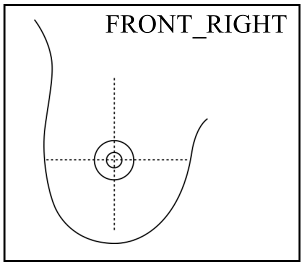
Zip: _ _ _ _ _ - _ _ _ _ Birth date: _ _ / _ _ / _ _ _ _ Age:_ _ _ _ _ _ _ _ _ Weight_ _ _ _ _ _ _ _ _ _ _ _

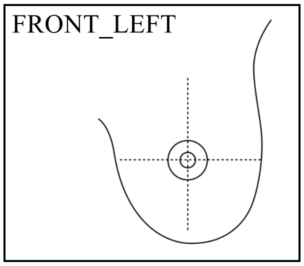
Home phone: (_ _ _ _ _) _ _ _ _ _ _ _ _ _ _ _ Office phone: (_ _ _ _ _ _) _ _ _ _ _ _ _ _ _ _ x _ _ _ _ _ _ _

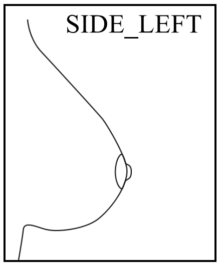
Patient's Doctor: _

Send copy of exam also to: _









Do you currently have: (please circle)

A Breast Lump	Yes	No	Rt	or	Lt
Breast Pain	Yes	No	Rt	or	Lt
Nipple Discharge	Yes	No	Rt	or	Lt
Breast Implants	Yes	No	Rt	or	Lt
Are you pregnant	Yes	No			

Patient's history (insert age)

Age 1st Menstruation: ______________________________ **Age of Menopause**: ______________________________

Age of Hysterectomy ______________________________ **Age of 1st Live Birth** ______________________________

or never pregnant______________________________

# of Live births:______________________________ **# of children breast fed**: ______________________________

Have you had a breast biopsy or surgery in the past? Yes No

Rt____________________ Date _____________ Lt__________________________ Date_______________

Have you had radiation therapy? Yes No

Have you ever had chemotherapy? Yes No

Have you ever had cancer? Yes No

If yes, what type? ____

Family history of breast cancer**?** Yes No

Mother Sister Daughter

Age of diagnosis ____

Have you had a previous mammogram? Yes No

Where?____ Date of Previous?_____________________

Was your previous mammogram under the same name? Yes No

Previous Name ____

Do you take Hormone Therapy?

Estrogen Yes No How Long? _____________________ **Progesterone** Yes No How Long? _____________________

Birth Control Pill Yes No How Long? _____________________

Tamoxifen Yes No How Long? ____________________________

Arimidex Yes No How Long? ____________________________

Have you had a change in your dose since your last mammogram? ____

Patient Signature ____ **Date** _________________________________