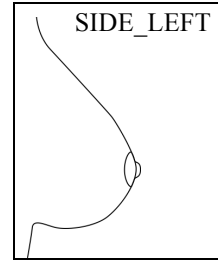
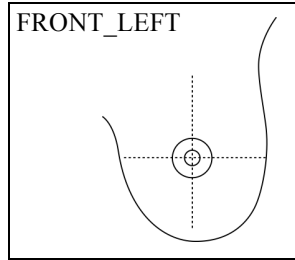
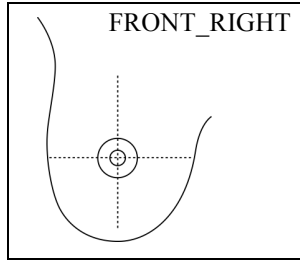
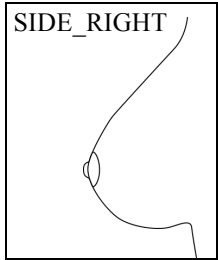


Last name: \_\_\_\_\_ First: \_\_\_\_\_ MI \_\_\_\_\_  
 Street : \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
 Zip: \_\_\_\_\_ Birth date: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Weight \_\_\_\_\_  
 Home phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Office phone: ( \_\_\_\_\_ ) \_\_\_\_\_ x \_\_\_\_\_  
 Patient's Doctor: \_\_\_\_\_  
 Send copy of exam also to: \_\_\_\_\_



**Do you currently have: (please circle)**

<b>A Breast Lump</b>	Yes	No	Rt	or	Lt
<b>Breast Pain</b>	Yes	No	Rt	or	Lt
<b>Nipple Discharge</b>	Yes	No	Rt	or	Lt
<b>Breast Implants</b>	Yes	No	Rt	or	Lt
<b>Are you pregnant</b>	Yes	No			

**Patient's history (insert age)**

Age 1<sup>st</sup> Menstruation: \_\_\_\_\_ Age of Menopause: \_\_\_\_\_

Age of Hysterectomy \_\_\_\_\_ Age of 1<sup>st</sup> 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** \_\_\_\_\_