Associated Physicians
Devoted Physicians, Trusted Care.

BREAST IMAGING PATIENT HISTORY FORM

Date: _____

Ordering Physician: _____

Preferred Phone number: _____

Place label here

May we leave a detailed message? ❑ Yes ❑ No

How would you like to receive your results? ❑ Mailed Letter ❑ MyChart

1. Do you use an insulin pump? ❑ Yes ❑ No

2. Have you had breast imaging studies at another facility? ❑ Yes ❑ No
   If so, where: _____

3. Do you have implants? ❑ Yes ❑ No
   If yes, what type? ❑ Saline ❑ Silicone ❑ Other: _____

4. Are you currently breastfeeding or are you possibly pregnant? ❑ Yes ❑ No
   what is the date of your last menstrual period? _____

5. Has it been 12+ months since your last period? ❑ Yes ❑ No

6. Have you had a hysterectomy? ❑ Yes ❑ No
   If so, at what age? _____

7. Have you given birth? ❑ Yes ❑ No
   If yes, what is the year of your first child's birth? _____

8. What is the approximate date of your last physical breast exam by your physician? _____

9. I, or my healthcare provider, feel/notice a **new breast issue**:
   ❑ Palpable lump or thickening ❑ Focal pain or tenderness ❑ Nipple discharge ❑ None

10. Have you had cancer of the uterus, cervix, ovaries or elsewhere? ❑ Yes ❑ No
    If yes, where? _____

11. Have you had childhood radiation for lymphoma? ❑ Yes ❑ No

12. Have you been diagnosed with breast cancer? ❑ Yes ❑ No
    If **yes**, have you had any of the following treatments?

❑ Lumpectomy	❑ Left	❑ Right
❑ Mastectomy	❑ Left	❑ Right
❑ Radiation Therapy (External Beam or Brachytherapy)	❑ Left	❑ Right
❑ Chemo Therapy	❑ Left	❑ Right
❑ Chemoprevention Therapy	❑ Left	❑ Right
Have you had an axillary node dissection?	❑ Left	❑ Right

(If possible please do not place IV for contrast in the same side of the dissection)

13. Have you had breast surgery or a breast procedure? ❑ Yes ❑ No

Image Guided Biopsy (Mammo, US, MRI)	❑ Left	❑ Right
Surgical/Excisional Biopsy	❑ Left	❑ Right
Cyst Aspiration	❑ Left	❑ Right
Breast Reduction	❑ Left	❑ Right

Other: _____

14. Do you have a family history of breast cancer? ❑ Yes ❑ No ❑ Unknown

If yes, who in your family had breast cancer? ❑ Aunt, cousin, grandmother
❑ Post-menopausal mother, sister, daughter
❑ Pre-menopausal mother, sister, daughter

15. Have you or any of your family members tested positive for the breast cancer gene BRCA 1 or BRCA 2? ❑ Yes ❑ No ❑ Unknown

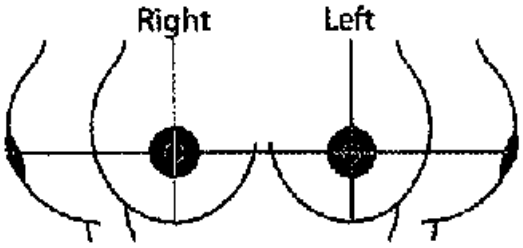
Please indicate which exam you would like performed today ❑ 2D Digital ❑ 3D Digital Breast Tomosynthesis

To the best of my knowledge, the above information is correct.

Patient Signature:_____ Date:_____

For Imaging Staff Use Only

Notes on positioning/Acquisition for the Radiologist



Tech Initials: _____