Patient

History

Questionnaires

Please review this form and provide us with any updated or missing information.

Medical Records #__________________

Last Name: ________________________ First Name: ____________________ MI:_____

DOB:__________ Age: _____ Height: ____ft____in Weight: _____

Is there any possibility that you are pregnant? **☐YES ☐NO**

Race: ____

☐ I have Ashkenazi Jewish ancestry. (Jewish with ancestors from Eastern Europe, usually Germany, Poland, Lithuania, Ukraine and Russia.)

Why are you here today? ☐ Right ☐ Left ☐ Bilateral

☐ Routine screening
☐ Specific complaint/concern *(specify below)*
____
☐ Recent breast cancer diagnosis
☐ History of breast cancer follow-up
☐ Diagnostic follow-up

Personal Medical History

☐ History of breast cancer at age: _____

☐ Right ☐ Left ☐ Bilateral

☐ Chemotherapy at age:_____ ☐ Radiation:______________ # of weeks

Breast Surgeries

☐ Lumpectomy ☐ Mastectomy ☐ Other: __________________

Date of surgery:____________ ☐ Right ☐ Left ☐ Bilateral

☐ Previous breast biopsies How many?: _____ Date:__________

☐ Right ☐ Left ☐ Bilateral Outcome:____________________

At age

☐ History of high-risk lesion (found on biopsy – examples include atypical hyperplasia, ADH, ALH, LCIS) _____

☐ History of other cancer(s)
____________________________ _____

☐ Previous chest radiation (mangle radiation- usually for lymphoma treatment) _____

Hormone History

	Currently using	Age at first use	Age at last use	Years of use
Hormonal Contraceptives	☐	_____	_____	_____ yrs
Estrogen	☐	_____	_____	_____yrs
Progesterone	☐	_____	_____	_____yrs
Tamoxifen	☐	_____	_____	_____ yrs
Evista	☐	_____	_____	_____ yrs
Arimidex	☐	_____	_____	_____ yrs
Unspecified hormones	☐	_____	_____	_____ yrs

Family History of Cancer ☐ Unknown/Adopted ☐ No known family history of cancer

Please list ONLY the following: breast, ovarian/fallopian tube/peritoneal, pancreatic, and prostate cancers.

Relative	Type	Approx. Age	Maternal/Paternal
__________	__________	_____	☐ ☐
__________	__________	_____	☐ ☐
__________	__________	_____	☐ ☐

If there are additional relatives with cancer that are not listed here, please discuss this with the technologist at the time of your exam.

Gynecological History

First menstrual period at age: __________

Age at time of first live birth of child: __________

☐ Premenopausal

☐ Perimenopausal

Menopause at age: _____

Left ovary removed at age: _____

Right ovary removed at age:_____

Hysterectomy at age:_____

Breast Implants

☐ Right Date: _________ ☐ Silicone Gel ☐ Saline

☐ Left Date: _________ ☐ Silicone Gel ☐ Saline

Genetic Testing: ***Genes related to cancer risk (i.e. BRCA 1/2)***

☐ I have been tested for a gene related to cancer risk

Outcome: ______________ Type:______________

☐ A family member has been genetically tested

Which relative?: ____________________

☐ Maternal ☐ Paternal

Outcome:______________ Type:______________

Outside Imaging History

Have you had imaging at an outside facility within the past 5 yrs?

	Location and approx. date(s)
☐ Mammogram	__________________
☐ Breast MRI	__________________
☐ Breast Ultrasound	__________________
☐ PET-CT scan	__________________
☐ Other:	__________________

My signature indicates that the information on this form is complete and correct.

Signature:____ Date: _____ / _____ / _____

Intake form provided by Invision Sally Jobe