

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

 Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Female  Male

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone:(\_\_\_\_\_) \_\_\_\_\_ Work Phone:(\_\_\_\_\_) \_\_\_\_\_ Ext.: \_\_\_\_\_

**Ethnic Origin:**  White  Black  American Indian, Eskimo, Aleut  Asian, Pacific Islander  
 (optional)  Other \_\_\_\_\_ Are you Hispanic?  Yes  No

 Is this your first mammogram ever?  Yes  No  
 If you have had previous mammograms, where were they done?  Baptist  South Miami  
 Doctors  Homestead  BMP  Other (please indicate where): \_\_\_\_\_

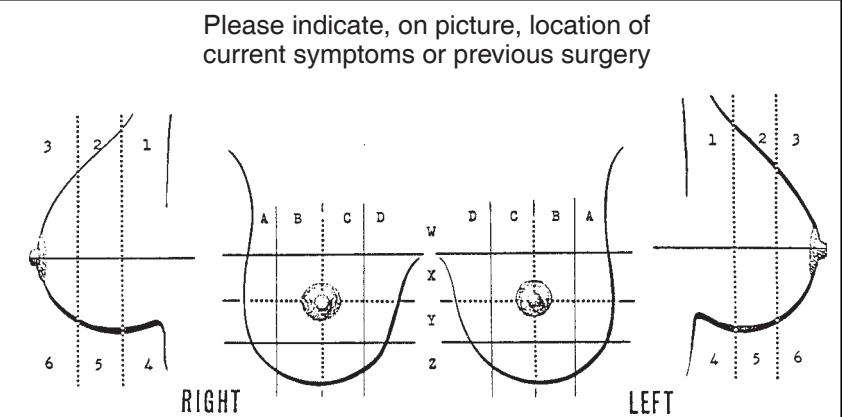
Referring Physician: DR. \_\_\_\_\_

<b>Medications:</b> <input type="checkbox"/> None <input type="checkbox"/> Estrogen <input type="checkbox"/> Progesterone <input type="checkbox"/> Birth Control Pills <input type="checkbox"/> Tamoxifen <input type="checkbox"/> Other (Please list) _____	How long? _____ _____ _____ _____	<b>Previous Treatment:</b> <input type="checkbox"/> None Cyst Aspiration <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Both Reduction Surgery <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Both Needle Biopsy <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Both Excisional Biopsy <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Both Lumpectomy <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Both Mastectomy <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Both Radiation Therapy <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Both Chemotherapy <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Both	When? _____ _____ _____ _____ _____ _____ _____
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**History:**  
 Age when menstruation began \_\_\_\_\_  
 Age when menstruation stopped \_\_\_\_\_  
 Date of last menstrual period \_\_\_\_\_  
 Have you had your ovaries removed?  Yes  No  
 Have you had a hysterectomy?  Yes  No  
 Number of full term pregnancies \_\_\_\_\_

**Do you have implants?**  Yes  No If so, please check type:  
 Silicone Gel  Saline  Combination  
 Pre-pectoral(in front of muscle)  Retro-pectoral(behind muscle)  
 Augmentation Mammoplasty  Other  Unknown

**To the best of my knowledge, I am not currently pregnant.** \_\_\_\_\_ (Signature)

**Risk Factors (check all that apply):**  None  
 No family history of breast cancer  
 Weak family history of breast cancer  
 Intermediate family history of breast cancer  
 Very strong family history of breast cancer  
 Personal breast cancer history  
 History of gynecologic cancer (uterus, ovaries)  
 History of high risk lesion on previous biopsy, LCIS  
 Post-menopausal patient  
 Nulliparous (no pregnancies)  
 Late child bearing (after 30)  
 If family history, age of when cancer found: \_\_\_\_\_

**Indicated Problems (check all that apply):**  None

<input type="checkbox"/> Palpable abnormality <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Lump or thickening <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Nipple abnormality <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Pain/tenderness <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Skin thickening <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Cancer elsewhere (please indicate): _____	How long? _____ _____ _____ _____ _____	<input type="checkbox"/> Large axillary lymph nodes <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Bloody discharge <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Non-bloody discharge <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Difficult physical exam <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Retraction on clinical exam <input type="checkbox"/> RT <input type="checkbox"/> LT	How long? _____ _____ _____ _____ _____
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