OUTPATIENT DIAGNOSTIC CENTER

PATIENT INFORMATION

Last Name	First Name/Middle Initial	DOB	Age	Race
		/ /		

Is today's evaluation your first mammogram: _____ yes _____ no

If not, year and location of your last mammogram_____

Year of your last breast exam performed by a healthcare professional_____

CURRENT SYMPTOMS

	Which breast?	Duration?
Lump:	L / R	_____
Nipple inversion:	L / R	_____
Discharge:	L / R	_____
Color of discharge:	_____	
Skin retraction:	L / R	_____
Tenderness :	L / R	_____

Other symptoms: _____

_____

HORMONE HISTORY

Date of your last menstrual period: _____

Have you ever taken hormones?: ___no __yes

If yes, list type (birth control pills, hormone replacement, etc) and dates of use:

_____

_____

_____

Breast fed in the last six months? ____no ___yes

Currently breast feeding? ____no ___yes

Weight changed by more than 15 lbs since your last mammogram? ____no ___yes

If yes, please specify:_____

BREAST SURGICAL & BIOPSY HISTORY

Breast reduction: ___no ___yes if yes, year _____

Implants: ___no ___yes if yes, year _____

Please list any previous benign breast surgeries or biopsies, including which breast and the approximate year:

_____

_____

_____

BREAST CANCER HISTORY

Have you ever had breast cancer? ____no ____yes

If yes, please answer the following:

Which breast? ____ right _____ left

Year of diagnosis: _____

Type of surgery: ___lumpectomy ___mastectomy

Did you have chemotherapy?: ____no ____yes

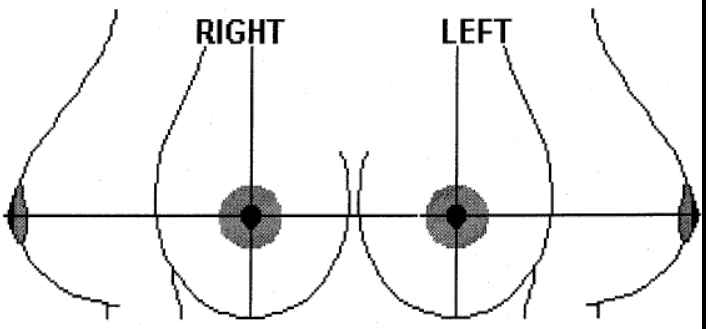
Did you have radiation?:_ ____no ____yes

Name of surgeon: _____

Name of medical oncologist: _____

Name of radiation oncologist: _____

FOR TECHNOLOGIST USE ONLY



TECHNOLOGIST COMMENTS

_____

TECHNOLOGIST SIGNATURE, DATE & TIME