Patient History Form

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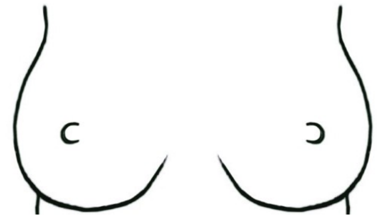
Name: ☐ Date of Birth: ☐

Have you had any prior mammograms? **Y** ☐ **N** ☐ If Yes, Where and when? ☐

TOMOSYNTHESIS Y ☐ **N** ☐ Insurance approval is needed or waiver must be signed.

Do you have any symptoms listed below? If so, please mark diagram.

R ☐ **L** ☐ **B** ☐ Palpable lump
R ☐ **L** ☐ **B** ☐ Breast Pain
R ☐ **L** ☐ **B** ☐ Thickening
R ☐ **L** ☐ **B** ☐ Nipple discharge color: ☐



Are you here for Ultrasound Only?
R ☐ **L** ☐ **B** ☐ History: ☐

Breast cancer risk factors:

- Please indicate history of breast cancer, BRCA +, LCIS, ADH or personal history of any other cancer*:* ☐
- Family history of breast cancer **Y** ☐ **N** ☐
  If yes, list relationship and age of diagnosis: ☐

Have you had an prior breast biopsy or surgical procedures? Y ☐ **N** ☐
R ☐ **L** ☐ **B** ☐ Surgical biopsy, lumpectomy, reduction or other surgical procedure
R ☐ **L** ☐ **B** ☐ Core needle biopsy
R ☐ **L** ☐ **B** ☐ Breast implants: Silicone ☐ Saline ☐ or Double Lumen ☐

Are you pregnant? Y ☐ **N** ☐
Are you breast feeding? Y ☐ **N** ☐
Are you taking Hormone Replacement Therapy or OCPs? Y ☐ **N** ☐

Patient Signature: ____ Date: ☐

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