

PARK WEST RADIOLOGY

BREAST HISTORY & MAMMOGRAM SCREENING SHEET

COMPLETED BY PATIENT

PATIENT NAME: _____ TODAY'S DATE: _____

DATE OF BIRTH: _____

PHONE # (H): _____ (W): _____ DATE OF LAST MAMMOGRAM: _____

WHERE: _____ REFERRING PHYSICIAN: _____

What is the reason for having this breast exam?

- This is a routine exam. I AM NOT HAVING ANY BREAST PROBLEMS.
- This is a short interval follow-up requested from my last exam (1-11 months ago).

I have a personal history of cancer. Date: _____ Location: _____

I am having the following new problem (s): *(please check R for right or L for left)*

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> New lump that can be felt | <input type="checkbox"/> R <input type="checkbox"/> L | <input type="checkbox"/> Breast pain | <input type="checkbox"/> R <input type="checkbox"/> L |
| <input type="checkbox"/> Other NEW thickening | <input type="checkbox"/> R <input type="checkbox"/> L | <input type="checkbox"/> Nipple problem | <input type="checkbox"/> R <input type="checkbox"/> L |
| <input type="checkbox"/> Bloody nipple discharge | <input type="checkbox"/> R <input type="checkbox"/> L | <input type="checkbox"/> Non-bloody spontaneous nipple discharge | <input type="checkbox"/> R <input type="checkbox"/> L |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> R <input type="checkbox"/> L | <input type="checkbox"/> Large Nodes under my arm | <input type="checkbox"/> R <input type="checkbox"/> L |

DATE OF LAST PHYSICAL BREAST EXAM PERFORMED BY YOUR PHYSICIAN: _____

Are you taking any of the following? YES NO

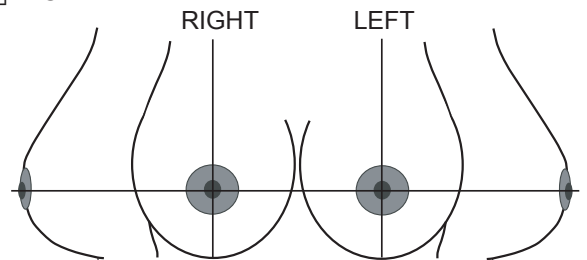
- | | | |
|--|----------------------|---------------------|
| <input type="checkbox"/> Estrogen Replacement Therapy? | Age first used _____ | Age last used _____ |
| <input type="checkbox"/> Tamoxifen/Arimidex | Age first used _____ | Age last used _____ |
| <input type="checkbox"/> Progesterone? | Age first used _____ | Age last used _____ |

IMPORTANT: Check the following THAT ARE TRUE FOR YOU:

- No one in my family has had breast cancer.
- My aunt, grandmother, cousin, father, uncle had breast cancer. Maternal or paternal
- My mother, sister had breast cancer after their periods had stopped. Age at diagnosis _____
- My mother, sister had breast cancer while they were still having their periods. Age at diagnosis _____
- I have had breast cancer. R L

Have you ever had any of the following procedures: YES NO

- | | | |
|---|-----------------------|-------------|
| <input type="checkbox"/> R <input type="checkbox"/> L | Cyst Aspiration | Date: _____ |
| <input type="checkbox"/> R <input type="checkbox"/> L | Needle biopsy | Date: _____ |
| <input type="checkbox"/> R <input type="checkbox"/> L | Excisional biopsy | Date: _____ |
| <input type="checkbox"/> R <input type="checkbox"/> L | Lumpectomy for Cancer | Date: _____ |
| <input type="checkbox"/> R <input type="checkbox"/> L | Mastectomy | Date: _____ |
| <input type="checkbox"/> R <input type="checkbox"/> L | Radiation Therapy | Date: _____ |



Screened by: _____

Entered in Mammobase by: _____

I verify that the answers I have provided to questions on this form are correct and understand that withholding information or inaccurate information may adversely affect the interpretation of this exam.

Patients signature: _____ Date: / /