

**NEW PATIENT
BREAST IMAGING
REGISTRATION
FORM**

TECHNICIAN INITIALS

M: TB KS SS MS LM
 US: JD DD RC

Account #: _____ Today's Date: _____

Name: Last _____ First _____

Date of Birth: _____ Age: _____

Date of last exams, if not done here:
 Mammogram: _____ Breast Sonogram: _____ Breast MRI: _____

Where was it done? _____

Send the report to the following physician(s): _____

Are you pregnant? Yes No First day of your last menstrual period: _____

Have you breastfed in the last three months? Yes No

Has there been a significant change in your weight since your last mammogram? Yes No

Please explain: _____

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 the following: (Please check R for right and L for left)
 - New lump that can be felt R L Skin changes R L
 - Other NEW thickening R L Nipple Problems R L
 - Large nodes under arm R L Other R L
 - Bloody or clear spontaneous nipple discharge R L

Please Explain: _____

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

Normal Abnormal R L

Please indicate if you have ever had any of the following procedures:

<input type="checkbox"/> No		DATE(S)
<input type="checkbox"/> Implants R <input type="checkbox"/> L <input type="checkbox"/> Saline <input type="checkbox"/> Silicone _____	<input type="checkbox"/> Breast reduction R <input type="checkbox"/> L <input type="checkbox"/>	_____
<input type="checkbox"/> Mastopexy (breast lift) R <input type="checkbox"/> L <input type="checkbox"/>		_____
<input type="checkbox"/> Cyst aspiration R <input type="checkbox"/> L <input type="checkbox"/>		_____
<input type="checkbox"/> Needle biopsy R <input type="checkbox"/> L <input type="checkbox"/>	<input type="checkbox"/> Atypical Hyperplasia <input type="checkbox"/> LCIS	_____
<input type="checkbox"/> Surgical biopsy R <input type="checkbox"/> L <input type="checkbox"/>	<input type="checkbox"/> Atypical Hyperplasia <input type="checkbox"/> LCIS	_____
<input type="checkbox"/> Lumpectomy for cancer R <input type="checkbox"/> L <input type="checkbox"/>		_____
<input type="checkbox"/> Mastectomy R <input type="checkbox"/> L <input type="checkbox"/>		_____
<input type="checkbox"/> Reconstruction R <input type="checkbox"/> L <input type="checkbox"/>		_____
<input type="checkbox"/> Pacemaker R <input type="checkbox"/> L <input type="checkbox"/>		_____
<input type="checkbox"/> Chemo Port R <input type="checkbox"/> L <input type="checkbox"/>		_____
<input type="checkbox"/> Radiation Therapy R <input type="checkbox"/> L <input type="checkbox"/>		_____
<input type="checkbox"/> Other R <input type="checkbox"/> _____	L <input type="checkbox"/> _____	_____

Please enter your menstrual history (where applicable):

Age when period started _____

Have you given birth to any children? Yes No

If yes, age at first term pregnancy _____

Age at menopause _____

Were your ovaries removed? Yes No

Have you ever had a hysterectomy? Yes No

Last menstrual period: _____

PLEASE LIST IF YOU REGULARLY TAKE OR HAVE HAD ANY OF THE FOLLOWING:

1. Any product that contains estrogen or progesterone (hormone replacement therapy, birth control, other)

2. Tamoxifen/Arimidex/Evista _____
3. Chemotherapy _____
4. All other prescription medications _____
5. Aspirin, Advil, or other anti-inflammatory medications _____
6. Are you allergic to any medications? Yes No List _____
7. List any serious medical conditions: _____

IMPORTANT - Check the followings that are true for you:

NO ONE IN MY FAMILY HAS HAD BREAST CANCER

One or more in the following relatives have had breast cancer:

- | | | |
|--|---|---|
| <input type="checkbox"/> Mother | Age at diagnosis: _____ | Number of breasts involved: _____ |
| <input type="checkbox"/> Father | Age at diagnosis: _____ | Number of breasts involved: _____ |
| <input type="checkbox"/> Sister(s) | Age at diagnosis: _____ | Number of breasts involved: _____ |
| <input type="checkbox"/> Brother(s) | Age at diagnosis: _____ | Number of breasts involved: _____ |
| <input type="checkbox"/> Daughter(s) | Age at diagnosis: _____ | Number of breasts involved: _____ |
| <input type="checkbox"/> Son(s) | Age at diagnosis: _____ | Number of breasts involved: _____ |
| <input type="checkbox"/> Grandmother(s) | <input type="checkbox"/> Maternal <input type="checkbox"/> Paternal | Age at diagnosis: _____ Number of breasts involved: _____ |
| <input type="checkbox"/> Grandfather(s) | <input type="checkbox"/> Maternal <input type="checkbox"/> Paternal | Age at diagnosis: _____ Number of breasts involved: _____ |
| <input type="checkbox"/> Aunt(s) | <input type="checkbox"/> Maternal <input type="checkbox"/> Paternal | Age at diagnosis: _____ Number of breasts involved: _____ |
| <input type="checkbox"/> Uncle(s) | <input type="checkbox"/> Maternal <input type="checkbox"/> Paternal | Age at diagnosis: _____ Number of breasts involved: _____ |
| <input type="checkbox"/> Other | <input type="checkbox"/> Maternal <input type="checkbox"/> Paternal | Age at diagnosis: _____ Number of breasts involved: _____ |
| <input type="checkbox"/> I have had breast cancer. | <input type="checkbox"/> R <input type="checkbox"/> L | Age at each diagnosis: _____ |
| <input type="checkbox"/> I have had a close family member with ovarian cancer. | Relation(s): _____ | |
| <input type="checkbox"/> I (or a close family member) have been tested for the BRCA genetic mutations. | | |
| <input type="checkbox"/> BRCA-1 <input type="checkbox"/> positive <input type="checkbox"/> negative | Relation(s): _____ | |
| <input type="checkbox"/> BRCA-2 <input type="checkbox"/> positive <input type="checkbox"/> negative | Relation(s): _____ | |

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

Patient's signature: _____

Date: _____

NOTE: If you have previous discs and/or reports with you, please give them to the receptionist at check-in.