BERGEN IMAGING CENTER, P.A.
WOMEN'S IMAGING SPECIALISTS OF ENGLEWOOD

NEW PATIENT BREAST IMAGING REGISTRATION FORM

TECHNICIAN INITIALS
M: □ TB □ KS □ SS □ MS □ LM
US: □ JD □ RC □ NB □ IB

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:

				DATE(S)
□ No				
□ Implants R □ L □ □ Saline □ Silicone _____			□ Breast reduction R □ L □	_____
□ Mastopexy (breast lift)	R □	L □		_____
□ Cyst aspiration	R □	L □		_____
□ Needle biopsy	R □	L □	□ Atypical Hyperplasia □ LCIS	_____
□ Surgical biopsy	R □	L □	□ Atypical Hyperplasia □ LCIS	_____
□ Lumpectomy for cancer	R □	L □		_____
□ Mastectomy	R □	L □		_____
□ Reconstruction	R □	L □		_____
□ Pacemaker	R □	L □		_____
□ Chemo Port	R □	L □		_____
□ Radiation Therapy	R □	L □		_____
□ Other	R □ _____		L □ _____	

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 REGULARY 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:

□ Mother			Age at diagnosis: _____	Number of breasts involved: _____
□ Father			Age at diagnosis: _____	Number of breasts involved: _____
□ Sister(s)			Age at diagnosis: _____	Number of breasts involved: _____
□ Brother(s)			Age at diagnosis: _____	Number of breasts involved: _____
□ Daughter(s)			Age at diagnosis: _____	Number of breasts involved: _____
□ Son(s)			Age at diagnosis: _____	Number of breasts involved: _____
□ Grandmother(s)	□ Maternal	□ Paternal	Age at diagnosis: _____	Number of breasts involved: ___
□ Grandfather(s)	□ Maternal	□ Paternal	Age at diagnosis: _____	Number of breasts involved: ___
□ Aunt(s)	□ Maternal	□ Paternal	Age at diagnosis: _____	Number of breasts involved: ___
□ Uncle(s)	□ Maternal	□ Paternal	Age at diagnosis: _____	Number of breasts involved: ___
□ Other	□ Maternal	□ Paternal	Age at diagnosis: _____	Number of breasts involved: ___

□ I have had breast cancer. □ R □ L Age at each diagnosis: _____

□ I have had a close family member with ovarian cancer. Relation(s): _____

□ I (or a close family member) have been tested for the BRCA genetic mutations.

□ BRCA-1 □ positive □ negative Relation(s): _____

□ BRCA-2 □ positive □ 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.