

**NEW PATIENT  
BREAST IMAGING  
REGISTRATION  
FORM**

**TECHNICIAN INITIALS**

M:  TB  KS  LM  CV  
 US:  JD  DH  DCB  DM

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)

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> New lump that can be felt                    | R <input type="checkbox"/> L <input type="checkbox"/> | <input type="checkbox"/> Skin changes    | R <input type="checkbox"/> L <input type="checkbox"/> |
| <input type="checkbox"/> Other NEW thickening                         | R <input type="checkbox"/> L <input type="checkbox"/> | <input type="checkbox"/> Nipple Problems | R <input type="checkbox"/> L <input type="checkbox"/> |
| <input type="checkbox"/> Large nodes under arm                        | R <input type="checkbox"/> L <input type="checkbox"/> | <input type="checkbox"/> Other           | R <input type="checkbox"/> L <input type="checkbox"/> |
| <input type="checkbox"/> Bloody or clear spontaneous nipple discharge | R <input type="checkbox"/> L <input type="checkbox"/> |  |   |

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"/>	<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

**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: \_\_\_\_\_
8. Are you allergic to **LATEX**?  Yes  No

**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.**