

**IMAGING SERVICES
BREAST SCREENING FORM**

PATIENT INFORMATION
(To be completed by Patient)

Name: _____	Age: _____	Date of Birth: _____/_____/_____
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Please check (✓) **Yes** or **No** and/or **Right** or **Left** to the following questions:

Do you feel a lump in either breast **NOW**? Yes No Right Left

Do you have pain or soreness in either breast **NOW**? Yes No Right Left

Do you have discharge or bleeding from nipples **NOW**? Yes No Right Left

If yes, color of discharge: _____

Have you **EVER** had breast surgery? Yes No Right Left

If yes, date of surgery: ____/____/____

What kind of surgery? Biopsy Lumpectomy Mastectomy Reduction Implants

Have you ever been diagnosed with breast cancer? Yes No

Has anyone in your family ever had breast cancer? Yes No

If yes, who? Mother Grandmother Sister Aunt Daughter Other: _____

Have you ever been diagnosed with ovarian cancer? Yes No

Has anyone in your family ever had ovarian cancer? Yes No

If yes, who? Mother Grandmother Sister Aunt Daughter Other: _____

Have you ever been diagnosed with any other type of cancer? Yes No

If yes, type: _____

Is there an possibility you may be pregnant? Yes No

Age at menopause: _____ Date of last menstrual cycle: ____/____/____

Age at hysterectomy: _____

Do you take birth control pills or hormones? Yes No

How Long: _____ Type: _____

Was your first child born **AFTER** you were **30** years old? Yes No

Have you ever had a mammogram? Yes No

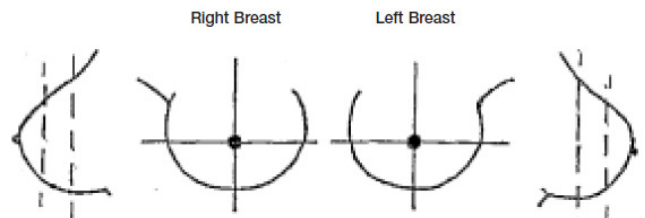
When was it done: _____

Where was it done: _____

EXAMINATION RESULTS – STAFF USE ONLY

Comments: _____

Mammographer: _____



Despite screening, not all breast cancers can be detected. In addition, abnormal screening results do not necessarily indicate the presence of a serious condition. Therefore, you are encouraged to discuss these results with your Physician. If you are experiencing breast-related symptoms, please see your doctor regardless of the outcome of the screening program.