Appt. time:_____ Arrival:_____ Paperwork Ready:_____ Ready for Tech:_____

FOR OFFICE USE ONLY

Patient History Form

Patient Name: _____ DOB: _____ Date: _____

Allergies: _____ _____ Chart #:_____

BRIEF HISTORY:

		CIRCLE ONE	
1.	Is there a possibility you could be pregnant?	YES	NO
2.	If premenopausal, when was your last period? _____		
3.	If post-menopausal, are you currently taking hormone replacement therapy?		
	a. Synthetic hormone replacement	YES	NO
	b. Bioidentical hormone replacement	YES	NO
4.	Have you ever been diagnosed with breast cancer?	YES	NO
5.	Have you ever been diagnosed with ovarian cancer?	YES	NO
6.	Any other health related issues since your last visit? _____		
	_____		

7. Please indicate below if any of the following relatives been diagnosed with cancer. If yes, was it paternal or maternal; pre or post menopause?

	CIRCLE ONE			CIRCLE ONE	CIRCLE ONE	
Mother	Breast	Ovarian	Other:_____		Pre-menopause	Post-menopause
Sister	Breast	Ovarian	Other:_____		Pre-menopause	Post-menopause
Grandmother	Breast	Ovarian	Other:_____	Paternal or Maternal	Pre-menopause	Post-menopause
Aunt	Breast	Ovarian	Other:_____	Paternal or Maternal	Pre-menopause	Post-menopause
Daughter	Breast	Ovarian	Other:_____		Pre-menopause	Post-menopause
Father	Breast	Prostate	Other: _____			
Other	Breast	Ovarian	Other:_____			

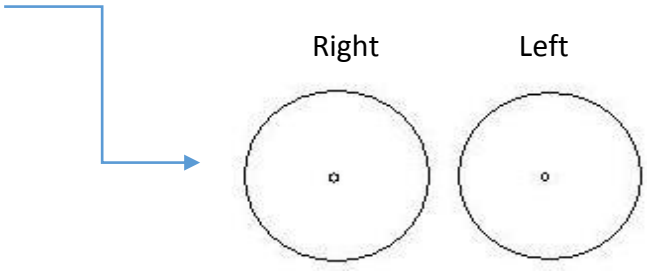
_____
Please explain relationship

Please answer all of the following questions. Print information as needed on form.

8. When was your last mammogram? _____
9. Where was it performed? _____

	CIRCLE ONE	
10. Have you noticed a bloody nipple discharge?	YES	NO
11. Do you have breast implants?	YES	NO
12. Have you noticed a new definite mass or hard knot in your breast?	YES	NO

13. If you are currently experiencing a problem please mark an X on the area of concern?



Patient Signature: _____ Date:_____