Arrival:_____________ Paperwork Ready:__________ Ready for Tech:____________ Reading Room: ___________

FOR OFFICE USE ONLY 2015v9

New Patient History Form

Last Name: ______________________ First: _______________________ MI: ___

DOB ___/___/____ Referring Physician: _____________________________

Date of Last Mammogram: ________________________

Location of last mammogram: ___________________________________

OFFICE USE ONLY:
Patient MRN :_________________
Patient Appt Date :_______________
Patient Appt Time :_______________

Please answer yes or no and the questions below:

Are you currently pregnant? Yes ____ No ____

Are you currently breastfeeding? Yes ____ No ____ Age at First Period? _________

How many pregnancies have you had? ____ #of live births? ____ Age at first childbirth? ________

Date of your last menstrual period? _________________

Have your ovaries been removed? Yes ___ No ___ Has your uterus been removed? Yes ___ No___

Please check the appropriate answer. I am having the following ***NEW*** breast problem:

Lump(s)	No Problems ____	Right breast ____	Left breast ____	Both breasts ____
Pain	No Problems ____	Right breast ____	Left breast ____	Both breasts ____
Nipple discharge	No Problems ____	Right breast ____	Left breast ____	Both breasts ____
Other problem:	______________________________________			

Have you had any of the following? (Please check all that apply)

Breast Implants Yes ___ No __ Please check type: Silicone ____ Saline ____

Breast Lift Yes ___ No ___

Breast Reduction Yes ___ No ___

Benign Surgical Biopsy *(not cancer)* Yes ___ No ___ Right-# BXS ___ Left -# BXS ___ Atypical Changes? Yes ____ No____

Needle Core Biopsy Yes ___ No ___ *Atypical Changes?* Yes ____ No _____

Lumpectomy (***for breast CA***) Yes ___ No ___ Right (date :__________) Left (date: __________)

Mastectomy *(for breast CA)* Yes ___ No ___ Right (date: __________) Left (date: __________)

Radiation Therapy *(for breast CA)* Yes ___ No ___ Partial breast radiation ___ Whole breast radiation___

Chemotherapy *(for breast cancer)* Yes ___ No ___

Antihormonal Therapy Yes ___ No ___

If diagnosed with breast cancer, what was your age when you were diagnosed? ____

Are you currently or have you ever taken any of the following? (Please check all that apply)

Birth control	Never ____	Currently____	For how long? ____	*Previously* ____	For how long? ____
Fertility drugs	Never ____	Currently ____	For how long? ____	*Previously* ____	For how long? ____
Hormones	Never ____	Currently ____	For how long? ____	*Previously* ____	For how long? ____

If yes to hormones, please ✓ which type Synthetic ____ Bio-identical ____

Has any family member ever been diagnosed with **breast cancer?** (Please check all that apply)

	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		

Are you of Ashkenazi Jewish Descent? Yes ____ No ___

Have you or a family member ever been diagnosed with **ovarian cancer**? Yes __ No __ Relationship ________________

Have you or a family member had genetic testing for breast cancer risk? Yes __ No __ Relationship ________________

Have you had radiation to the chest for lymphoma or other cancer? Yes __ No __ Age ______________________

Please list any other cancers in your family: (family member, type, age diagnosed) ______________________________

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Patient signature: ____________________________________ Date: ____________________