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___

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) _____

Patient signature: _____ Date: _____