FOR OFFICE USE ONLY Arrival:___________ Paperwork Ready:_________ Ready for Tech:___________ Reading Room: __________

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? _________________ Height: ___________ Weight:________

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 ☐	Maternal ☐	Pre-menopause ☐	Post-menopause ☐
Aunt	Breast ☐	Ovarian ☐	Other: ________	Paternal ☐	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: ________________