

<b>PRIOR STUDIES:</b>								
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DATE OF LAST CLINICAL EXAM:			<b>Last MRI:</b>		<b>Life Time Risk:</b>	
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<b>INDICATED PROBLEMS :</b>	Please check appropriate boxes and comment.			Comments:
<input type="checkbox"/> Palpable Abnormality	<input type="checkbox"/> Nipple Discharge	<input type="checkbox"/> Other		
<input type="checkbox"/> Nipple Abnormality	<input type="checkbox"/> Pain or Soreness	<input type="checkbox"/> N/A		

FAMILY HISTORY OF CANCER				PERSONAL HISTORY OF CANCER		
Relationship	Maternal/ Paternal	Type	Age	Type	Age	Treatment Radiation/Chemo

<b>BRCA TESTED?</b>	<input type="checkbox"/> NO	<input type="checkbox"/> YES ( <input type="checkbox"/> Positive <input type="checkbox"/> Negative )	<b>NOTES:</b>
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BREAST BIOPSIES/SURGERIES/OTHER:			
Type	Side/Clock	Date	Results

GYNECOLOGICAL HISTORY:										
Age of First Menstrual Period:		Menopause age:		Medications:			RESULTS:			
# of live births:		Hysterectomy age:		Type	Past	Current	<u>EXAM</u>	<u>BIRAD</u>	<u>TECH</u>	<u>MD</u>
Age at 1st Pregnancy:		Age Right ovary removed:		Birth Control	<input type="checkbox"/>	<input type="checkbox"/>	MAMMO			
# of children breast fed:		Age Left ovary removed:		Hormone Replacement	<input type="checkbox"/>	<input type="checkbox"/>	GG			
Do you have implants?	<input type="checkbox"/> Yes <input type="checkbox"/> No			Infertility	<input type="checkbox"/>	<input type="checkbox"/>	SONO			
If yes, complete below:	Date:			Synthroid	<input type="checkbox"/>	<input type="checkbox"/>	MRI			
Saline: <input type="checkbox"/> Right <input type="checkbox"/> Left				Tamoxifen	<input type="checkbox"/>	<input type="checkbox"/>	DENSITY	a	b	
Silicone: <input type="checkbox"/> Right <input type="checkbox"/> Left				Arimidex	<input type="checkbox"/>	<input type="checkbox"/>		c	d	
Textured <input type="checkbox"/> Right <input type="checkbox"/> Left				Femora	<input type="checkbox"/>	<input type="checkbox"/>	<b>comments:</b>			
Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No			Other	<input type="checkbox"/>	<input type="checkbox"/>				
Last Menstrual Period:				<i>I agree that the above information is correct.</i>						
Ashkenazi Jewish Ancestry:	<input type="checkbox"/> Yes <input type="checkbox"/> No		Patient Signature:							