Breast Care Center
Breast Imaging History

Name:__________________________
DOB:___________
MR#:___________
OR
Label

Your **daytime** telephone number is:__________________
List doctor(s) you want to receive a copy of your results:____

Fill in the blanks or check (√) your answers below:

1. **Where and when** was your last mammogram and/or breast ultrasound?

   ____

2. **When** was the last time your doctor examined your breasts? ____

3. Are you **currently having a breast problem**? ☐ Yes ☐ No **Which breast**? ☐ Right ☐ Left ☐ Both

   Type of problem: Solitary lump
   Nipple discharge
   Pain
   Armpit swelling

4. Have you ever had **breast surgery**? ☐ Yes ☐ No **Which breast**? ☐ Right ☐ Left ☐ Both

   Type of surgery: Biopsy Date:_____________________________
   Date:_____________________________
   Implants Date:_____________________________
   Reduction Date:_____________________________

5. Have you ever had **breast cancer**? ☐ Yes ☐ No **Which breast**? ☐ Right ☐ Left ☐ Both

   Lumpectomy? ☐ Yes ☐ No **Which breast**? ☐ Right ☐ Left ☐ Both
   Mastectomy? ☐ Yes ☐ No **Which breast**? ☐ Right ☐ Left ☐ Both
   Radiation Therapy? ☐ Yes ☐ No **Which breast**? ☐ Right ☐ Left ☐ Both
   Chemotherapy? ☐ Yes ☐ No

   Date your surgery/treatment started?__________________________________

6. Do you have a **family history of breast cancer**? ☐ Yes ☐ No If yes, **list relative and age of diagnosis**:

   Mother at age:_________________
   Sister at age:__________________
   Daughter at age:________________
   Aunt at age:____________________
   Grandmother at age:_____________

7. Are you **currently using hormones** (examples: estrogen, progesterone, depo provera, birth control pills, patch)?

   ☐ Yes ☐ No If yes, **how long**:_________________

8. Are you **currently**: **Before menopause**? ☐ Yes ☐ No (one or more periods over last year)
   After menopause? ☐ Yes ☐ No (no periods or spotting over last year)
   Pregnant? ☐ Yes ☐ No
   Breastfeeding? ☐ Yes ☐ No If yes, **how long**:_________________

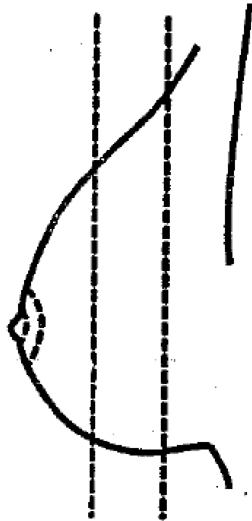
LOURDES

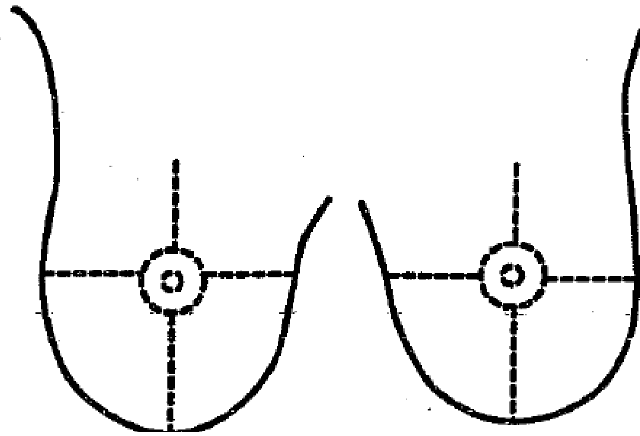
Breast Care Center
Breast Imaging History

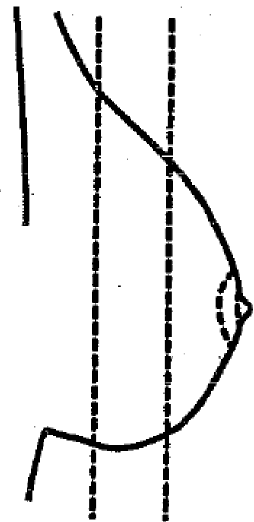
Mammography Number:_________________________

Mammographer:________________________________

Equipment Cleaned







Comments: