Pt. Name:
Date of Birth:
MRN #:

LABEL

St.JosephHealth
St. Joseph Heritage Medical Group
A member of the St.Joseph Hoag Health alliance

BREAST PATIENT HISTORY

☐ No ☐ Yes Are you pregnant, or could you be pregnant?

☐ No ☐ Yes Previous Mammogram? If yes, where_____ Date: _____
☐ No ☐ Yes Previous Breast MRI? If yes, where_____ Date: _____

☐ No ☐ Yes Have you or a family member had breast cancer under age 50?
☐ No ☐ Yes Have two or more cases of breast cancer on the same side of your family?
☐ No ☐ Yes Have you or a family member had ovarian cancer?
☐ No ☐ Yes Have you or a family member had both breast and ovarian cancer?
☐ No ☐ Yes Are you Ashkenazi Jewish with a personal or family history of breast or ovarian cancer?
☐ No ☐ Yes Have you or a family member had male breast cancer?

☐ No ☐ Yes Do you take hormones now? If yes, name:_____ How long? _____
☐ No ☐ Yes Have you taken hormones in the past? If yes, start date:_____ End date: _____

☐ No ☐ Yes Do you have breast implants? If yes, when?_____ Type? _____
☐ No ☐ Yes Have your implants ever been replaced? If yes, when?_____
☐ No ☐ Yes Have you had implants permanently removed? If yes, when? _____
☐ No ☐ Yes Have you had breast reduction or breast lift surgery? If yes, when?_____

☐ No ☐ Yes Any benign needle biopsies? If yes, which breast: ☐ Right ☐ Left When? _____
☐ No ☐ Yes Any benign surgical excisions? If yes, which breast: ☐ Right ☐ Left When?_____
☐ No ☐ Yes Do you have a pacemaker? _____

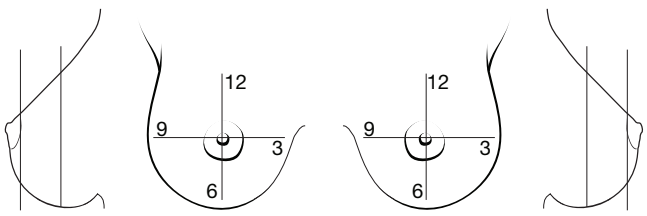
☐ No ☐ Yes Have you ever been diagnosed with breast cancer?
- ☐ Lumpectomy: ☐ Right - when?_____ ☐ Left - when? _____
- ☐ Mastectomy: ☐ Right - when?_____ ☐ Left - when? _____
- ☐ Chemotherapy: Start date:_____ End date: _____
- ☐ Radiation Therapy: Start date:_____ End date: _____
- ☐ Endocrine Therapy (Tamoxifen, Arimidex, Femara, etc.): Start:_____ End: _____
- ☐ Other, please describe:_____

☐ No ☐ Yes Have you had cancer elsewhere in your body? If yes, type?_____ When? _____

☐ No ☐ Yes Any **NEW** breast problems? If yes, please check all that apply:
- ☐ Pain/tenderness ☐ Right ☐ Left
- ☐ Lump ☐ Right ☐ Left
- ☐ Nipple discharge ☐ Right ☐ Left Color of discharge:_____
- ☐ Nipple retraction ☐ Right ☐ Left
- ☐ Skin changes ☐ Right ☐ Left
- ☐ Other ☐ Right ☐ Left Please describe:_____

Patient Signature: _____ Date:_____

FOR TECHNOLOGIST ONLY



Right Left

Technologist signature_____ Date: _____