Imaging Center for Women

Office Use Only:

MRN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2D \_\_\_\_\_ 3D \_\_\_\_\_ Diag \_\_\_\_\_ Sc\_\_\_\_\_

US \_\_\_\_\_ Dexa \_\_\_\_\_

My Chart\_\_\_\_\_ Mail \_\_\_\_\_

1300 Hospital Drive, Suite 100

Fredericksburg, VA 22401

540-741-3250

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring MD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Have you ever had a mammogram?** Yes No

 If yes, please give the date and location of your last mammogram

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Do you perform self-breast exams?** Yes No
2. **Within the past 2 years have you ever had any nipple discharge?** Yes No

 If yes, which breast? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What color? \_\_\_\_\_\_\_\_\_\_\_\_\_

 What year and for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 How did you notice it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **4. Are you CURRENTLY having any NEW breast pain? Side?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Yes No

 If yes, is it localized or diffuse? \_\_\_\_\_\_\_\_\_\_\_\_\_ How long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does it come and go or is it constant? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5. Do you or your Doctor CURRENTLY feel a NEW lump in your breast(s)?** Yes No

 **Side and how long?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HORMONE HISTORY**

1. Are you currently using **oral** estrogen therapy? Yes No

 If yes, how long? \_\_\_\_\_\_ Last used \_\_\_\_\_\_ Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you currently using **oral** progesterone therapy? Yes No

 If yes, how long? \_\_\_\_\_\_ Last used \_\_\_\_\_\_ Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OBGYN HISTORY**

1. # of children birthed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **9.** Age first menstruation: \_\_\_\_\_\_\_\_\_\_\_\_\_
2. Age at first live birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **11.** Age of menopause: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **12.** Age of first full term pregnancy: \_\_\_\_\_\_\_\_\_\_\_\_\_ **13.** Last Period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **14.** Ablation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

  **15.** Hysterectomy **Age**: Total \_\_\_\_\_\_ Partial \_\_\_\_\_\_ Ovaries Removed\_\_\_\_\_\_ Uterus Removed \_\_\_\_\_\_

**MEDICAL HISTORY**

**16. Have you been diagnosed with breast cancer or DCIS (Ductal Carcinoma in-situ)?** Yes No

 If yes, did you have a Lumpectomy Mastectomy Side? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 If yes, did you have radiation treatment and when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No

 If yes, did you have chemotherapy and when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No

**17.** **Have you been diagnosed with hyperplasia, atypical hyperplasia or** Yes No

 **LCIS (Lobular Carcinoma in-situ)**?

**18.** **Have you been tested for the Breast Cancer Gene?** Yes No

 If yes, are you: BRCA1 positive BRCA2 positive Negative

 **OVER**

**PRIOR PROCEDURE HISTORY**

**19.** **Have you ever had breast surgery and/or biopsy?** Yes No

 If yes, what year? \_\_\_\_\_\_\_\_\_\_\_ Which breast? \_\_\_\_\_\_\_\_\_\_\_\_\_

**20. Do you have breast implants?** If yes, saline or silicone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No

**FAMILY HISTORY**

 **(Maternal or Paternal)**

**21.** **Do you have a family history of breast cancer? (Mother, Daughter, Sister, Aunt, etc.)** Yes No

 If yes, who?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age at Diagnosis \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age at Diagnosis \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age at Diagnosis \_\_\_\_\_\_\_\_\_\_\_\_\_

**22.** **Self or family history of Uterine, Cervical or Ovarian Cancer?** Yes No

 If yes, who and what type?

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age at Diagnosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type \_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age at Diagnosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type \_\_\_\_\_\_\_\_\_\_\_\_

**23. How many sisters do you have?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**24.** **Height:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **26.** **Weight:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **25. Do you have an insulin pump? If so, what type?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 

Tech Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Rad Notes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tech: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Radiologist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_