Office Use Only:

MRN: _____

2D _____ 3D _____ Diag _____ Sc_____
US _____ Dexa _____

My Chart_____ Mail _____

Imaging Center for Women
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
   _____
2. **Do you perform self-breast exams?** Yes No
3. **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

6. Are you currently using **oral** estrogen therapy? Yes No
   If yes, how long? _____ Last used _____ Name _____
7. Are you currently using **oral** progesterone therapy? Yes No
   If yes, how long? _____ Last used _____ Name _____

OBGYN HISTORY

8. # of children birthed: _____
9. Age first menstruation: _____
10. Your age at first pregnancy: _____
11. Age of menopause: _____
12. Your age at first live birth: _____
13. Last Period: _____
14. Uterine Ablation: Yes No Date if Yes: _____
15. How many sisters do you have?_____
16. Hysterectomy **Age**: Total _____ Partial _____ Ovaries Removed_____ Uterus Removed _____

PRIOR PROCEDURE HISTORY

17. **Have you ever had breast surgery and/or biopsy?** Yes No
    If yes, what year? _____ Which breast? _____
18. **Do you have breast implants?** If yes, saline or silicone _____ Yes No

OVER ➡

MEDICAL HISTORY

19. 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

20. Have you been diagnosed with hyperplasia, atypical hyperplasia or LCIS (Lobular Carcinoma in-situ) of the breast? Yes No

21. Have you been tested for the Breast Cancer Gene? (Genetic blood test) Yes No
If yes, are you: BRCA1 positive BRCA2 positive Negative

FAMILY HISTORY

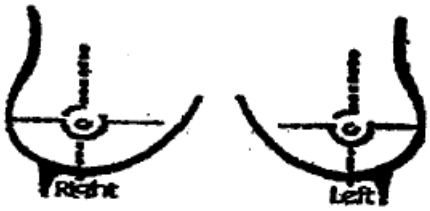
(Maternal or Paternal)

22. 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 _____

23. 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 _____

24. Height: _____ **25. Weight:** _____

26. Do you have an infusion pump? If so, what type? _____



Tech Notes: _____ Rad Notes:_____

_____ _____

_____ _____

Tech: _____ Radiologist: _____