Tech Use only:
Covid Vaccine: Y or N
1st ____ 2nd ______ Side R or L
Date 1st______________
Date 2nd ______________

MRN: ____________________

2D _____ 3D _____ Diag _____ Sc_____

US _____ Dexa _____

Imaging Center for Women
1300 Hospital Drive Ste. 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. Age at first pregnancy: ____________________ 11. Age of menopause: ________________
12. Age at first live birth: ______________________ 13. Last period: _______________________
14. Uterine Ablation: YES NO Date if yes:_____________
15. Hysterectomy: Total ______ Partial ______ Ovaries Removed______ Uterus Removed ______
16. How many biological sisters do you have?___________ Half sisters? Paternal________Maternal_______

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, LCIS (Lobular Carcinoma in-situ), or Radial Scar? Yes No

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

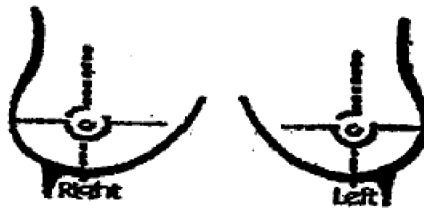
FAMILY HISTORY

22. Do you have a family history of breast cancer? (Mother, Daughter, Sister, Aunt, Father, Grandfather 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 insulin pump? If so, what type? ________________________________



Tech Notes: _________________________ Rad Notes: ____________________________

____________________________________ ________________________________

____________________________________ ________________________________

Tech: ______________________________ Radiologist: ________________________