Male Breast Imaging Patient History

Patient Name: (first & last) _____ **Date:** _____

Date of Birth: _____ **Phone #:** _____ **Ordering Physician:** _____

Instructions for Completing the Form: Check Yes or No. If "Yes" circle affected breast and answer question.

Yes No

☐ ☐ 1. Have you had a previous mammogram? If Yes, When_____ Where_____

☐ ☐ 2. Have you had a previous Breast MRI or Breast Ultrasound? If Yes, When_____ Where_____

☐ ☐ 3. Are you having any NEW areas of pain in your breasts? Left Right Both How Long? _____

☐ ☐ 4. Have you or your doctor recently found a NEW lump or mass in your breasts? Left Right Both How Long? _____

☐ ☐ 5. Are you having any NEW nipple discharge or NEW puckering of the skin or nipple? Left Right Both How Long? _____

☐ ☐ 6. Have you had any prior breast biopsies or surgery? Check all that apply:

	Left	Right	Procedure Date		Left	Right	Procedure Date	Comments
Surgical Biopsy				Reduction				
Core Biopsy				Implants				
Aspiration				Injury/Trauma				

☐ ☐ 7. Have YOU ever been diagnosed with BREAST cancer (personal history of breast cancer)?

Check all that apply:	Left	Right	Both	Procedure Date	Check all that apply:	Left	Right	Both	Last Treatment Date
Mastectomy					Chemotherapy # of treatments				
Lumpectomy					Radiation # of treatments				

☐ ☐ 8. Have YOU had any other type of cancer ? If Yes, Type?_____ Site?_____ Diagnosis Date?_____

☐ ☐ 9. Have you had radiation treatments to your chest ?

☐ ☐ 10. Are you taking any hormone therapy ?

☐ ☐ 11. Have you experienced weight loss or gain of 10 lbs or more? If yes, explain_____

12. What is the date of your last menstrual period? Estimated Date:_____

Family History If Yes, circle all that apply

☐ ☐ 13.Do you have a FAMILY history of BREAST cancer? Mother Sister Daughter Other_____

Age Diagnosed _____ _____ _____ _____

Please list current medications and supplements:_____

TO ALL MAMMOGRAPHY PATIENTS:

- I understand that mammograms do not detect all breast cancers, and that they must be combined with periodic physical exam, monthly breast self-exam, and comparison with any prior mammograms.
- I understand that any time I develop a ***NEW*** breast problem OR if I am having any new breast problems now, it is my responsibility to report this to my physician, and also to the technologist at the time of my mammogram.
- I understand that anytime I have been scheduled for a screening mammogram but have a ***NEW*** breast problem, I may need to have a diagnostic mammogram and/or breast ultrasound, which my physician will need to order.
- I understand that I must contact my physician for my final mammogram results.

_____ _____ _____ _____ _____

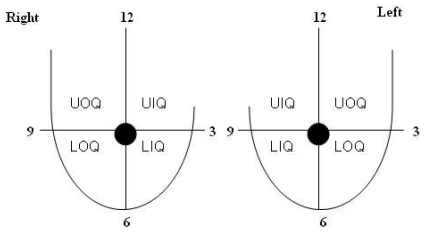
Date Time Patient/Legally Authorized Person/Care Giver Signature Print Name Relationship

☐Phone

_____ OR ☐Video _____ _____ _____

Qualified Staff/Interpreter Signature (Check) Print Qualified Staff/ Interpreter Name ID Number Language Interpreted

FOR TECHNOLOGIST USE ONLY: **Technologist Comments:**



_____

_____

_____

☐ **Physician Script** ☐ **EMR Script**

Draw surgical scars above

Patient Label or

Patient Name_____

_____ _____ _____ _____

Date **Time** **Technologist Signature** **Print Name**

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