Patient Name_____

Number of term pregnancies? _____ Age at first pregnancy? _____ Is it possible you may be pregnant? ☐ **YES** ☐ **NO**

Age of first period? _____ Date of last menstrual period? _____ Height_____ Weight_____

Do you take any of the following hormone replacements (HRT)?

☐ Estrogen____yrs. ☐ Progesterone____yrs. ☐ Birth Control Pills____yrs. ☐ Thyroid Medicine____yrs.

Have you taken any of the following hormone replacements (HRT) within the last 5 years?

☐ Estrogen____yrs. ☐ Progesterone____yrs. ☐ Birth Control Pills____yrs. ☐ Thyroid Medicine____yrs.

Do you have any new breast problems? ___**NO** **OR:**

	Right	Left
☐ Lump	☐	☐
☐ Pain	☐	☐
☐ Nipple Secretion	☐	☐
☐ Other (Please Describe)		

Color _____

Have you had breast surgery? ____**NO** **OR**: Are you of Ashkenzai Jewish decent? ☐ Yes ☐ No

Breast Surgery	**Right**	**Year**	**Left**	**Year**
☐ Biopsy	☐		☐	
☐ Lumpectomy (cancer)	☐		☐	
☐ Lumpectomy w/radiation	☐		☐	
☐ Mastectomy	☐		☐	
☐ Reconstruction	☐		☐	
☐ Implants	☐		☐	
☐ Reduction	☐		☐	

Do you have a family history of breast cancer or ovarian cancer? ____**NO** **OR:**

	Age of Diagnosis		Mother Side	Father Side
☐ Mother				
☐ Sister				
☐ Daughter				
☐ Other_____		Relationship _____	☐	☐

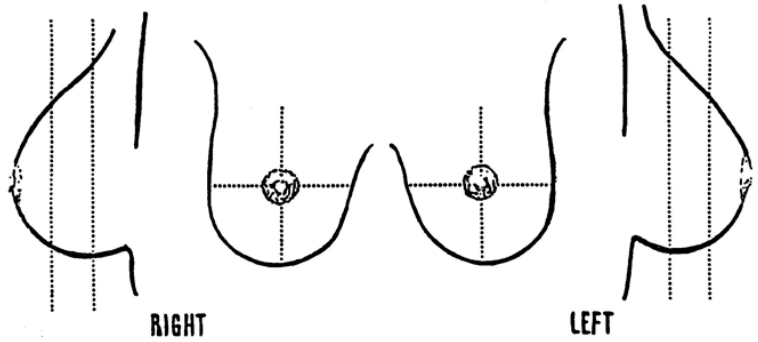
Have you had genetic testing? ☐ Yes ☐ No Family History of genetic testing? ☐ Yes ☐ No Results_____

Have you had a previous mammogram? ☐ **NO** **OR:** Date of last mammogram_____ Where was it done? _____

The above information has been completed accurately and to the best of my knowledge

Patient or Authorized Signature _____ Date_____

FOR OFFICE USE ONLY



☐ Bilat ☐ Right ☐ Left
☐ Baseline ☐ Diagnostic
☐ Screening ☐ Follow up

	N	Y
Family History	☐	☐
Breast Surgery	☐	☐
Breast Cancer Risk	☐	☐

RT
Signature_____ Date_____ Time_____

BREAST HISTORY
AdventHealth Imaging Center
Roeland Park, KS 66205
Form# 66471 04-01-2021

RADHXSC