



Account #: \_\_\_\_\_ Tech: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**BREAST IMAGING WORKSHEET (FEMALE)**

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

DATE OF LAST EXAMS, IF NOT DONE HERE:

MAMMOGRAM: \_\_\_\_\_ BREAST SONOGRAM: \_\_\_\_\_ BREAST MRI: \_\_\_\_\_

WHERE WAS IT DONE? \_\_\_\_\_

ARE YOU PREGNANT?  YES  NO

What is the reason for having this breast exam?

- This is a routine exam. I AM NOT HAVING ANY BREAST PROBLEMS.
- This is a short interval follow-up requested from my last exam (1-11 months ago).
- I have the following: *(Please check R for right and L for left.)*

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> New lump that can be felt                    | R <input type="checkbox"/> L <input type="checkbox"/> | <input type="checkbox"/> Skin changes   | R <input type="checkbox"/> L <input type="checkbox"/> |
| <input type="checkbox"/> Other NEW thickening                         | R <input type="checkbox"/> L <input type="checkbox"/> | <input type="checkbox"/> Nipple problem | R <input type="checkbox"/> L <input type="checkbox"/> |
| <input type="checkbox"/> Large nodes under my arm                     | R <input type="checkbox"/> L <input type="checkbox"/> | <input type="checkbox"/> Other _____    | R <input type="checkbox"/> L <input type="checkbox"/> |
| <input type="checkbox"/> Bloody or clear spontaneous nipple discharge | R <input type="checkbox"/> L <input type="checkbox"/> |   |   |

DATE OF LAST BREAST PHYSICAL EXAM PERFORMED BY YOUR PHYSICIAN: \_\_\_\_\_

- NORMAL
- ABNORMAL R  L

Please indicate if you ever had any of the following procedures:

- |  |   |   | DATE(S)                       |
|--|---|---|-------------------------------|
| <input type="checkbox"/> Implants                | R <input type="checkbox"/> L <input type="checkbox"/> | <input type="checkbox"/> Saline <input type="checkbox"/> Silicone | _____                         |
| <input type="checkbox"/> Breast reduction        | R <input type="checkbox"/> L <input type="checkbox"/> |   | _____                         |
| <input type="checkbox"/> Mastopexy (breast lift) | R <input type="checkbox"/> L <input type="checkbox"/> |   | _____                         |
| <input type="checkbox"/> Cyst aspiration         | R <input type="checkbox"/> L <input type="checkbox"/> |   | _____                         |
| <input type="checkbox"/> Needle biopsy           | R <input type="checkbox"/> L <input type="checkbox"/> | <input type="checkbox"/> atypical hyperplasia                     | <input type="checkbox"/> LCIS |
| <input type="checkbox"/> Excisional biopsy       | R <input type="checkbox"/> L <input type="checkbox"/> | <input type="checkbox"/> atypical hyperplasia                     | <input type="checkbox"/> LCIS |
| <input type="checkbox"/> Lumpectomy for cancer   | R <input type="checkbox"/> L <input type="checkbox"/> |   | _____                         |
| <input type="checkbox"/> Mastectomy              | R <input type="checkbox"/> L <input type="checkbox"/> |   | _____                         |
| <input type="checkbox"/> Reconstruction          | R <input type="checkbox"/> L <input type="checkbox"/> |   | _____                         |
| <input type="checkbox"/> Pacemaker               | R <input type="checkbox"/> L <input type="checkbox"/> |   | _____                         |
| <input type="checkbox"/> Chemo port              | R <input type="checkbox"/> L <input type="checkbox"/> |   | _____                         |
| <input type="checkbox"/> Radiation Therapy       | R <input type="checkbox"/> L <input type="checkbox"/> |   | _____                         |
| <input type="checkbox"/> Other _____             |   |   | _____                         |

Please enter your menstrual history (where applicable):

Age when periods started \_\_\_\_\_ Have you given birth to any children?  YES  NO

If yes, age at first term pregnancy \_\_\_\_\_

Age at menopause (if applicable) \_\_\_\_\_

Were your ovaries removed?  YES  NO Last menstrual period \_\_\_\_\_

Please list if you regularly take any of the following:

- 1) Any product that contains estrogen or progesterone (hormone replacement therapy, birth control, other) \_\_\_\_\_
- 2) Tamoxifen/Arimidex/chemotherapy \_\_\_\_\_
- 3) Evista \_\_\_\_\_
- 4) All other prescription medications \_\_\_\_\_
- 5) Aspirin, Advil, or other anti-inflammatories \_\_\_\_\_

**IMPORTANT:** Check the following THAT ARE TRUE FOR YOU:

No one in my family has had breast cancer.

One or more of the following relatives have had breast cancer:

- |                                      |                         |                                   |
|--------------------------------------|-------------------------|-----------------------------------|
| <input type="checkbox"/> Mother      | Age at diagnosis: _____ | Number of breasts involved: _____ |
| <input type="checkbox"/> Father      | Age at diagnosis: _____ | Number of breasts involved: _____ |
| <input type="checkbox"/> Sister(s)   | Age at diagnosis: _____ | Number of breasts involved: _____ |
| <input type="checkbox"/> Brother(s)  | Age at diagnosis: _____ | Number of breasts involved: _____ |
| <input type="checkbox"/> Daughter(s) | Age at diagnosis: _____ | Number of breasts involved: _____ |
| <input type="checkbox"/> Son(s)      | Age at diagnosis: _____ | Number of breasts involved: _____ |

- |   |   |                        |                                  |
|---|---|------------------------|----------------------------------|
| <input type="checkbox"/> Grandmother(s) | <input type="checkbox"/> Maternal <input type="checkbox"/> Paternal | Age at diagnosis: ____ | Number of breasts involved: ____ |
| <input type="checkbox"/> Grandfather(s) | <input type="checkbox"/> Maternal <input type="checkbox"/> Paternal | Age at diagnosis: ____ | Number of breasts involved: ____ |
| <input type="checkbox"/> Aunt(s)        | <input type="checkbox"/> Maternal <input type="checkbox"/> Paternal | Age at diagnosis: ____ | Number of breasts involved: ____ |
| <input type="checkbox"/> Uncle(s)       | <input type="checkbox"/> Maternal <input type="checkbox"/> Paternal | Age at diagnosis: ____ | Number of breasts involved: ____ |

I have had breast cancer. R  L  Age at each diagnosis: \_\_\_\_\_

I have had ovarian cancer. Age at diagnosis: \_\_\_\_\_

My close family member has had ovarian cancer. Relation(s): \_\_\_\_\_

I (or a close family member) have been tested for the BRCA genetic mutations:

- |                                 |                                 |                                   |                                   |                 |
|---------------------------------|---------------------------------|-----------------------------------|-----------------------------------|-----------------|
| <input type="checkbox"/> BRCA-1 | <input type="checkbox"/> BRCA-2 | <input type="checkbox"/> positive | <input type="checkbox"/> negative | Relation: _____ |
| <input type="checkbox"/> BRCA-1 | <input type="checkbox"/> BRCA-2 | <input type="checkbox"/> positive | <input type="checkbox"/> negative | Relation: _____ |
| <input type="checkbox"/> BRCA-1 | <input type="checkbox"/> BRCA-2 | <input type="checkbox"/> positive | <input type="checkbox"/> negative | Relation: _____ |

List any serious medical conditions: \_\_\_\_\_