Patient History Form

Name: _____ Date of Birth: _____

How did you hear about Bay Radiology? _____

Reason for today's exam:

○ Screening mammography (no symptoms or problems) **OR**

○ Diagnostic mammography (problem solving exam); reason:

- ○ Follow-up prior imaging ○ R ○ L _____
- ○ Palpable lump ○ R ○ L _____
- ○ Nipple discharge ○ R ○ L _____
- ○ Breast pain ○ R ○ L _____
- ○ Other ○ R ○ L _____

Your personal history:

○ Y ○ N Have you had breast or ovarian cancer? _____

○ Y ○ N Any other cancers? _____

○ Y ○ N Current hormone use? _____

○ Y ○ N Is there any chance you could be pregnant today?

Last menstrual cycle date: _____ Age at first pregnancy, if applicable: _____

Your family history: Please include relatives on both your mother's (maternal) side and father's (paternal) side. Please list who is affected and age at diagnosis if known. (*Example:* Breast cancer: mother - 65, mat aunt 40s to 50s).

○ Y ○ N Family history of breast, ovarian, or uterine cancer? _____

_____

○ Y ○ N Bilateral (both sides) breast cancer? _____

○ Y ○ N Any other cancers? _____

_____

Your breast procedure history:		**When/Result:**
○ Y ○ N	Biopsy – Needle or surgical	○ R ○ L _____
○ Y ○ N	Lumpectomy or mastectomy	○ R ○ L _____
○ Y ○ N	Radiation therapy to chest	○ R ○ L _____
○ Y ○ N	Breast implants	○ R ○ L _____
○ Y ○ N	Breast reduction or lift	○ R ○ L _____

Pt signature: _____ Date:_____

---------- **Lines below are for use at additional (future) visits** ----------

I confirm that changes to the above have been made in blue ink today:

Pt signature: _____ Date:_____

Pt signature: _____ Date:_____

Pt signature: _____ Date:_____

Pt signature: _____ Date:_____

-------FOR OFFICE USE------