TRI-CITY RADIOLOGY

BREAST Imaging Evaluation Form

PATIENT NAME: ______________________ **AGE:** ______ **Weight:** _____ **DATE:** __________

Referring Physician: ____

Reason for having exam: ____

1 Have you had any breast imaging before? **YES / NO** If yes, where & when? ____________

2 First day of LMP? ______________________

3. Please check any problems listed below that you are currently having.

a	Nipple discharge?	Right breast ______	Left breast ______
b	Pain in breasts?	Right breast ______	Left breast ______
c.	Lump in breasts?	Right breast ______	Left breast ______
d.	Nipple inversion?	Right breast ______	Left breast ______

4. Have you had breast cancer? **YES / NO** Ovarian cancer? **YES / NO**

5. Have you had radiation or chemotherapy for breast cancer treatment? **YES / NO**

6. Is there any family history of breast cancer? **YES / NO**

a. **Mother:** _____ Age: _____ **Sister**: _____ Age. _____ **Daughter**: _____ Age: _____

Other: ______________ Age: _____ **Premenopausal?** **YES / NO**

7. Have you had any surgery on your breasts? **YES / NO**

a.	**Biopsy**.	Right ____	Left ____	When: ____________________
b	**Mastectomy**:	Right ____	Left ____	When: ____________________
c.	**Lumpectomy**:	Right ____	Left ____	When: ____________________
d.	**Implants**:	Right ____	Left ____	When: ____________________
e.	**Reduction**:	Right ____	Left ____	When: ____________________

8. Do you take hormone pills or birth control pills? **YES / NO**
9. Number of pregnancies: ______How many children?: _____ Age at first pregnancy: ______
10. Have you had a hysterectomy? **YES / NO** Age: ______
11 Do you examine your breasts regularly? **YES / NO**

Exam performed by. ______________