Elevation Medical
IMAGING

Breast Imaging Patient History Sheet

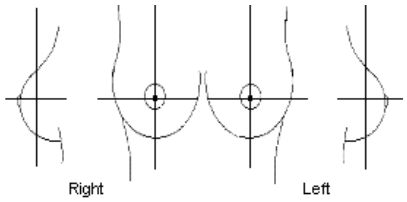
Name: _____ Date of Birth: _____

Preferred Phone Number: _____ Provider: _____

When and Where was your last mammogram? _____

Have your or your doctor noticed any <u>NEW:</u> (Circle No or Yes)

-Breast Lumps	No	Yes	-If Yes: Right or Left	When change noticed? _____
-Nipple Discharge	No	Yes	-If Yes: Right or Left	When change noticed? _____
-Change in Breast appearance?	No	Yes	-If Yes: Right or Left	When change noticed? _____



Technologist Notes: _____

HORMONE FACTORS

Do you currently take hormones? No Yes -If yes: Type? _____ Number of Years? _____

Have you had a hysterectomy? No Yes -If Yes: At what age? _____

--If No: Date of last menstrual cycle? _____ Or at what age? _____

How old were you when you had your first menstrual cycle? _____

How many children have you had? _____ Did you breastfeed? Yes No

How old were you when you had your first child? _____

SELF

Personal history of Breast Cancer? No Yes -If Yes: Right or Left Date Diagnosed? _____

(Check Treatments Below)

- ☐ Lumpectomy
- ☐ Mastectomy
- ☐ Radiation Therapy
- ☐ Chemotherapy
- ☐ Axillary node dissection

History of Breast Biopsy?	No	Yes	-If Yes: Right or Left	Date? _____
History of Breast Reduction Surgery?	No	Yes	-If Yes: Right or Left	Date? _____
Any Breast Augmentation (Implants)	No	Yes	-If Yes: Right or Left	Date? _____
Any history of breast injury?	No	Yes	-If Yes: Right or Left	Date? _____

FAMILY

Any **family history** of **Breast Cancer**? No Yes -If Yes: Relationship? _____

Age they were diagnosed? _____

Has any BRCA gene testing been done? No Yes Results? _____

Any family history of Ovarian Cancer? No Yes Relationship? _____

Age they were diagnosed? _____