Women's Imaging Center
Trico Sycamore Plaza Medical Office Building
431 S. Batavia St., Suite 100
Orange, CA 92868
Phone: 714-771-8360
Fax: 714-771-8364

Women's Imaging Center - Breast History

Patient Name: ______________________________ **Patient ID:** __________
(last) *(first)* *(m.i.)*

DOB: ____/____/______ **Age:** ______ **Exam Name:** ____________________ **Exam Date:** __________
MM DD YYYY

Referring Physician: ______________________________

☐ No ☐ Yes **Are you having any problems with your breast __today?__ If yes, please check all that apply:**

☐ Pain/tenderness ☐ Right ☐ Left
☐ Lump ☐ Right ☐ Left
☐ Nipple discharge ☐ Right ☐ Left
☐ Other ☐ Right ☐ Left
☐ Nipple retraction ☐ Right ☐ Left
☐ Skin changes ☐ Right ☐ Left
Color of discharge: ______________________
Please describe: ______________________

☐ No ☐ Yes **Is this your baseline (1st) mammogram?**
☐ No ☐ Yes **Previous Mammogram? If yes, Where?**__________________ **Date:** __________
☐ No ☐ Yes **Previous Breast MRI? If yes, Where?**__________________ **Date:** __________
☐ No ☐ Yes **Has your physician performed a breast exam recently? If yes, When?** __________

☐ No ☐ Yes **Are you pregnant?** ☐ No ☐ Yes **Nursing?** **Last menstrual period?** __________
Age at first menstruation: __________ **Age at first childbirth:**__________ ☐ **No children**

☐ No ☐ Yes **Have you ever been diagnosed with breast cancer?** ☐ **Right - when?**______ ☐ **Left - when?**______
☐ No ☐ Yes **Any Breast Cancer treatments? If yes, please check all that apply: [treatments]**

☐ Lumpectomy: ☐ Right - when? __________ ☐ Left - when? __________
☐ Mastectomy: ☐ Right - when? __________ ☐ Left - when? __________
☐ Chemotherapy: Start date: __________ End date: __________
☐ Radiation Therapy: Start date: __________ End date: __________
☐ Endocrine Therapy (Tamoxifen, Arimidex, Femara, etc.): Start date: __________ End date: __________
☐ Other, please describe: ______________________________

☐ No ☐ Yes **Do you have breast implants? When?**__________________ ☐ **Silicone** ☐ **Saline**
☐ No ☐ Yes **Have your implants ever been replaced or removed? When?**__________________
☐ No ☐ Yes **Have you had breast reduction or breast lift surgery? When?** __________________
☐ No ☐ Yes **Personal history of benign breast procedures?**

Please Continue on the Back Side

☐ No ☐ Yes Any benign needle biopsies? ☐ Right - when? ________ ☐ Left - when? ________

☐ No ☐ Yes Any benign surgical excisions? ☐ Right - when? ________ ☐ Left - when? ________

☐ No ☐ Yes Personal history of ovarian cancer? When? ________

☐ No ☐ Yes Personal history of other cancer? When? ________ Type? ________

☐ No ☐ Yes Do you take hormones/birth control now? How long? ________

☐ No ☐ Yes Family history of breast or ovarian cancer?

Relation: ________ Age: ____ ☐ Maternal ☐ Paternal

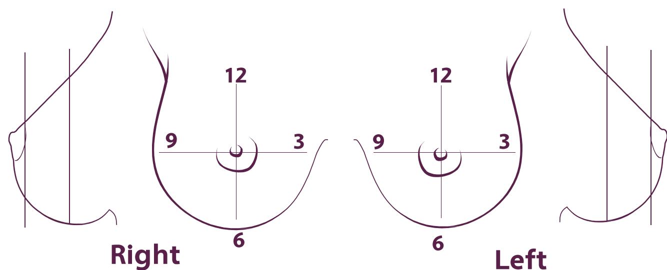
Relation: ________ Age: ____ ☐ Maternal ☐ Paternal

☐ No ☐ Yes Genetic testing: (BRCA1/2, PTEN) Type? ________ When? ________

By signing this form, I indicate that the above is true and correct.

Patient Signature ________________ **Date** ________

For Technologist Only



= Scar

● = Mole

▲ = Palpable mass

︿ = Pain

X = ? area

Limitations

____

____

____

____

Tech: ________

Prior BiRad: ________