ColumbiaDoctors NewYork-Presbyterian
212-326-8518
www.columbiaradiology.org

Imaging *BREAST IMAGING HISTORY FORM*

NAME _____ DATE _____

DATE OF BIRTH _____ AGE ____ PHYSICIAN(S)_____

EMAIL:_____ TO RECEIVE REPORTS _____

_____

DAY PHONE_____ EVENING PHONE_____

YOUR ADDRESS _____

_____

Could you be pregnant? ☐ **Yes** ☐ **No** ***Inform the technologist if you are or think you may be pregnant.***

Inform the technologist if you have today applied deodorant, antiperspirant, powder or lotion on the breast.

How do you prefer to be contacted, if it should be necessary? _____

When did your doctor last do a breast exam (physical exam) (month and year)?_____

Have you had a mammogram before? ☐ Yes ☐ No When?_____ Where?_____

Please circle ROUTINE or RIGHT (R) or LEFT (L)

Reason for today's mammogram/ultrasound:

ROUTINE
I feel a lump. ☐R ☐L
I feel a thickening. ☐R ☐L
My doctor feels something. ☐R ☐L
Nipple discharge. ☐R ☐L
New nipple change. ☐R ☐L
Pain ☐R ☐L
Follow something on prior ☐R ☐L

BREAST HISTORY - Have you ever had

(☐) breast cancer ☐ R ☐L date_____
(☐) breast biopsy ☐ R ☐L date_____
result_____
(☐) cyst aspiration ☐ R ☐L date_____
(☐) cyst removed ☐ R ☐L date_____
(☐) breast reduction ☐ R ☐L date_____
(☐) abscess treated ☐ R ☐L date_____
(☐) breast implant ☐ R ☐L date_____

Last menstrual period _____ If you have stopped having periods, at what age did they stop?_____

Have you had your ovaries removed? ☐ YES ☐ NO YEAR_____

Have you had ovarian carcinoma? ☐ Yes ☐ No

HORMONE USE

Have you ever used female hormones (including vaginal creams, suppositories, or patches) such as estrogen? ☐ YES ☐ NO
If you have, between what ages? _____ to_____ Are you presently using them? ☐ YES ☐ NO

FAMILY HISTORY (Please *indicate age* at which cancer was diagnosed)

Who has had breast cancer, and at what age? _____
Who has had ovarian carcinoma, and at what age? _____

BREAST CANCER TREATMENT (Please circle)

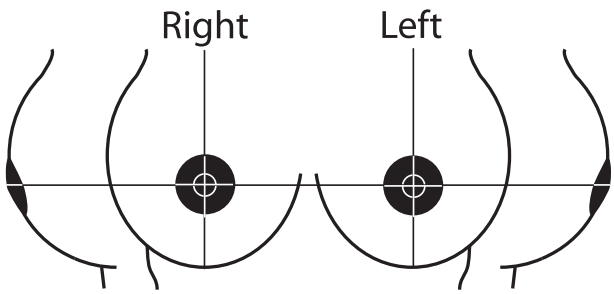
Have you had a mastectomy or lumpectomy? ☐ YES ☐ NO If so, which side? RIGHT LEFT
Have you ever had radiation therapy to your breasts? ☐ YES ☐ NO If yes, when?_____
Have you ever had chemotherapy for breast cancer? ☐ YES ☐ NO If yes, when?_____

TECHNOLOGIST COMMENTS:

_____
_____
_____
_____

TECHNOLOGIST USE ONLY:

SCARS AND SKIN LESIONS



CUSTOMER COMPLAINTS CALL: 1-800-838-7715
FACILITY #: 183020, ACR# 18002275463