TRI-CITY RADIOLOGY

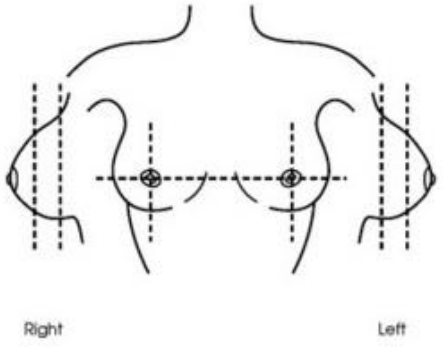
BREAST IMAGING EVALUATION FORM

PATIENT NAME: _____**AGE:**_____**DATE:**_____

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: _____