

Kelsey-Seybold Clinic®

Changing the way health cares.™

Name: _____ MRN: _____ DOB: _____ Today's date: _____
 Age: _____ Height: _____ Weight: _____ Day time phone: _____

Reason for Current Exam

- Routine (no problems)
- Current breast lump: Right Left Both If yes, how long: _____ Was lump felt by: Self Doctor Other: _____
- Nipple discharge: Right Left Both If yes, how long: _____ Color: _____;
 single duct or multiple ducts; Does it occur: when manually expressed or on its own
- Change in breast appearance Right Left Both If yes, how long: _____
- Other: _____

Family History

- Yes No Relatives with breast cancer?
- If yes, who: Mother Sister Daughter Aunt Grandmother Other relative: _____
- Age cancer was found: _____

Personal History

- Yes No **Have you previously been diagnosed with breast cancer? If yes, which breast?** Right Left Both
- Yes No Have you had radiation therapy on breasts or chest? If yes, which breast? Right Left Both Chest
- Yes No Are you pregnant now? Date of last menstrual cycle: _____ Age at first menstrual cycle: _____
- Yes No Have you had a hysterectomy? If yes, date: _____
- Yes No Are you post-menopausal?
- Yes No Are you taking any hormones or birth control pills?

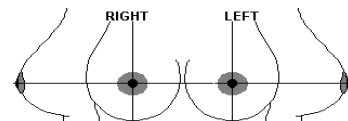
Prior mammogram: _____

Prior breast ultrasound or breast MRI: _____

Have you had any of the follow breast biopsies or surgeries:

- Yes No **Ultrasound Biopsy/Cyst aspiration** If yes, date: _____ Which breast? Right Left Both
- Yes No **Stereotactic Biopsy?** If yes, date: _____ Which breast? Right Left Both
- Yes No **Surgical or Excisional Biopsy?** If yes, date: _____ Which breast? Right Left Both
- Yes No **Lumpectomy or Mastectomy?** If yes, date: _____ Which breast? Right Left Both
- Yes No **Implants** If yes, date: _____ Which breast? Right Left Both
- Yes No **Reduction** If yes, date: _____ Which breast? Right Left Both
- Yes No Do you have any scars on your breasts? If yes, which breast? Right Left Both
- Yes No Do you have any moles on your breast? If yes, which breast? Right Left Both
- Yes No Do you have skin breakdown/tears under your breast? If yes, which breast? Right Left Both

Patient Signature: _____



Mammography Technologist: _____

Comments:
