Name: _____ (LAST, FIRST)

DOB: _____

Today's exam Date: _____

HARTSDALE IMAGING
BREAST HISTORY WORKSHEET
SCREEN / DIAG / US

MRN: _____

AGE: _____

Last time your doctor physically examined your breasts (Not Mammogram): _____

Are you **currently** having any **NEW breast problem**? ☐ Yes ☐ No

If yes, discussed with your doctor? ☐ Yes ☐ No

If yes (circle): Rt Lt Both ☐ Lump ☐ Pain ☐ Discharge ☐ Other _____

Any possibility of pregnancy? ☐ Yes ☐ No

Are you currently taking female hormones or birth control pills? Name: _____ ☐ Yes ☐ No

Do you have a personal history of **breast cancer**? IF YES PLEASE COMPLETE BELOW ☐ Yes ☐ No

IF YES TO ABOVE QUESTION

Year _____ Side _____

Surgical treatment: lumpectomy / mastectomy / none (circle)

Radiation therapy? ☐ Yes ☐ No

Have you had any **non-cancerous (benign)** breast procedures? (CIRCLE WHICH):

Ex: reduction, lift, implants, cyst aspiration, needle biopsy or surgical biopsy ☐ Yes ☐ No

If yes: Year _____ Side _____ Procedure _____

If yes: Year _____ Side _____ Procedure _____

Have you or any family members (CIRCLE WHO) (Myself, Mother, Father, Siblings, Children, Half-Siblings, Aunts, Uncles Grandparents, Nieces, Nephews, Great Aunts / Uncles, Great Grandparents, First Cousins) been diagnosed with any of the following: state which cancer _____

(1) Are you of Jewish ancestry **and** have Breast,Ovarian or Pancreatic Cancer (you or family member)? ☐ Yes ☐ No

(2) Breast cancer diagnosed at or before the age of 50? ☐ Yes ☐ No

(3) Two separate diagnoses of breast cancer or breast cancer in both breasts? ☐ Yes ☐ No

(4) Male breast cancer at any age? ☐ Yes ☐ No

(5) Ovarian cancer at any age? ☐ Yes ☐ No

(6) Pancreatic cancer at any age? ☐ Yes ☐ No

(7) Colon cancer at 50 years of age or younger? ☐ Yes ☐ No

(8) Endometrial (uterine) cancer at or under 50 years of age? ☐ Yes ☐ No

(9) A combination of 3 or more cancers on the same side of the family, circle all that apply: (colon, endometrial, ovarian, stomach, small bowel, biliary tract, kidney, brain, pancreatic, prostate, breast) ☐ Yes ☐ No

(10) Have you or a family member ever been tested for hereditary risk of cancer (e.g. BRCA, Lynch Syndrome)? If yes: Who was tested? _____ Result: _____ ☐ Yes ☐ No

What year tested? _____ Where/Which Company Tested: _____

Is this your first mammogram? ☐ Yes ☐ No

Were prior exams (mammograms, breast ultrasounds, breast MRI) done elsewhere? (circle which) ☐ Yes ☐ No

If yes Where: _____ When: _____

I certify that the information above is complete, correct and contains all pertinent information for my breast study today.

NAME: Printed _____ Signature _____

SECTION BELOW TO BE FILLED OUT BY TECH ONLY

☐ Screening ☐ Diagnostic ☐ Follow-up ☐ Recall ☐ Other _____

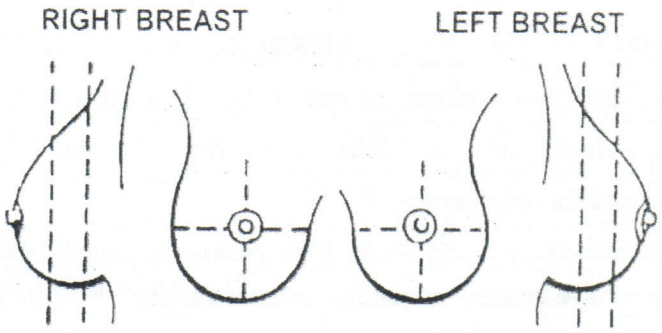
COMMENTS:_____

_____

_____

_____

Tech Initials: _____



Technologist initials_____

Patient watched video Yes ☐ No ☐ If no, reason: _____

Patient spoke with genetic counselor Yes ☐ No ☐ If no, reason: _____

Patient tested with myRisk Yes ☐ No ☐ If no, reason: _____

Patient declined evaluation ☐