

Name: _____
(LAST, FIRST)

HARTSDALE IMAGING BREAST HISTORY WORKSHEET

MRN: _____

DOB: _____

AGE: _____

SCREEN / DIAG / US

Today's exam Date: _____

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: _____

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

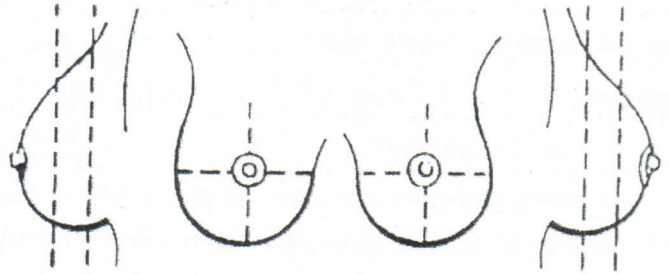
Screening Diagnostic Follow-up Recall Other _____

COMMENTS: _____

Tech Initials: _____

RIGHT BREAST

LEFT BREAST



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