PINK DOOR IMAGING

Patient History

UPDATED YEARLY

Annual Screening □
Diagnostic □
Follow Up □

First Name_____ **Last Name**_____

Date of Birth_____ **Age**_____ **Referring Physcian**_____

Have you ever had a Mammogram? □Y N□ Date of last Mammogram _____

Have you ever had a Prior Breast Ultrasound? □Y □N Date of last Ultrasound _____

Age period started____ Pregnant □Y □N Currently taking hormones or birth control? □Y □N

Today's Concerns:

New breast lump since last mammogram? □Left Right□ Both□

New pain or tenderness □Left Right□ Both□ Nipple discharge □Left Right□ Both□

How long have you had these symptoms____ Referring Physician Aware □Y N□

Breast History

Any Needle Biopsy □Yes □No □Left □Right □Both (if so) what year_____
Surgical Biopsy □Yes □No □Left □Right □Both (if so) what year_____

Personal History of Breast Cancer □YES NO□ IF "**YES**" Please check which apply.
□Lumpectomy □Radiation □Mastectomy □Chemotherapy □Hormone Therapy

Breast Implants □Yes No□ Original Year___Replaced Year_____ Reduction (R) (L) Year__

Family History

FAMILY HISTORY OF OVARIAN CANCER CIRCLE (YES) OR (NO) if so, list below

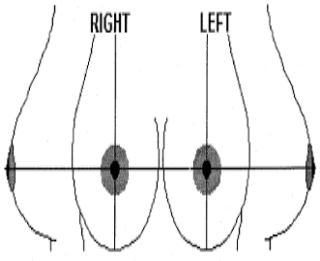
FAMILY HISTORY BREAST CANCER CIRCLE (YES) OR (NO) if so, list below.

List family relation & age of Diagnosis_____

Patient Signature_____ Date_____

**********OFFICE USE BELOW**********

Date of Prior Mammogram



BC#_____ SCREENING□ IMPLANTS□ DX□ R□ L□ BI□