

Please review this form and provide us with any updated or missing information.



Jacket # _____

Last Name _____ First Name _____ MI _____

DOB _____ Age _____

Height _____ Weight _____

Race _____

- I have Ashkenazi Jewish ancestry.
(Jewish with ancestors from Eastern Europe, usually Germany, Poland, Lithuania, Ukraine and Russia)

Family History of Cancer Unknown/Adopted

Please include breast, ovarian, endometrial (uterine), colon and prostate cancer.

Relative	Type	Approx Age	Maternal	Paternal
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

If there are additional relatives with cancer that are not listed here, please discuss this with the technologist at the time of your exam.

Why are you here today?

- I am here for routine screening
 I have a specific complaint/concern

Personal Medical History

- History of breast cancer at age _____
 Right Left Bilateral
 Date of surgery _____
 Lumpectomy Right Left Bilateral
 Mastectomy Right Left Bilateral
 Chemotherapy at age _____
 Radiation _____
 # of weeks _____
- Previous breast biopsies How many? _____ At age _____
- History of high-risk lesion
(found on biopsy - examples include atypical hyperplasia, ADH, ALH, LCIS) _____
- History of ovarian cancer _____
- History of colon cancer _____
- History of endometrial (uterine) cancer _____
- History of other cancer _____
- Previous chest radiation (mantle radiation-usually for lymphoma treatment) _____

Gynecological History

First day of last menstrual period _____
 First menstrual period at age _____
 Number of live births _____
 Age at time of first live birth of child _____
 Premenopausal
 Perimenopausal
 Menopause at age _____
 Left ovary removed at age _____
 Right ovary removed at age _____
 Hysterectomy at age _____

Breast Implants

Implant Consent:

- Right Date _____ Silicone Gel Saline
 Left Date _____ Silicone Gel Saline

Genetic Testing

- I have been tested for the "breast cancer gene" (BRCA)
 Outcome _____
- A family member has been tested for the BRCA gene.
 Which relative? _____
 Maternal Paternal
 Outcome _____

Hormone History

	Currently Using	Age at first use	Age at last use	Years of use
Hormonal Contraceptives	<input type="checkbox"/>	_____	_____	_____ yrs
Estrogen	<input type="checkbox"/>	_____	_____	_____ yrs
Progesterone	<input type="checkbox"/>	_____	_____	_____ yrs
Tamoxifen	<input type="checkbox"/>	_____	_____	_____ yrs
Raloxifene	<input type="checkbox"/>	_____	_____	_____ yrs
Arimidex	<input type="checkbox"/>	_____	_____	_____ yrs
Unspecified hormones	<input type="checkbox"/>	_____	_____	_____ yrs

Outside Imaging History

Have you had imaging at a non-ISJ facility within the past 5 yrs?
 Location and approx date(s)

- Mammogram _____
 Breast MRI _____
 Breast Ultrasound _____
 PET-CT scan _____
 Other: _____

My signature indicates that the information on this form is complete and correct.

Signature: _____ Date: ____/____/____

FOR OFFICE USE ONLY

Prior Study Comparison OS Release Done/Staff initials _____