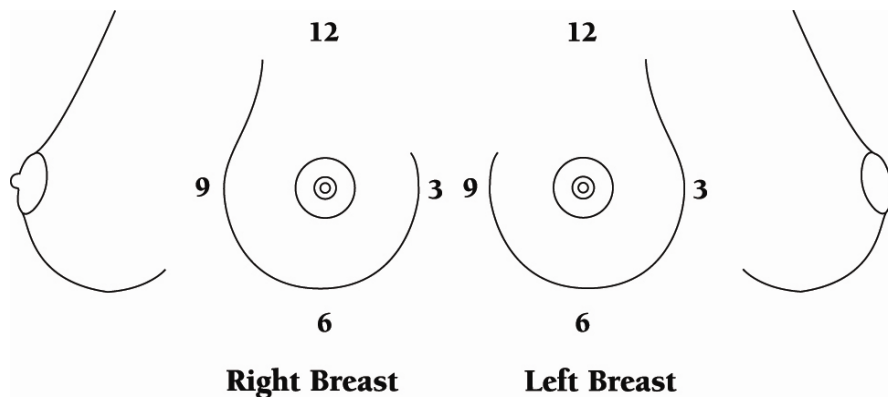


Date of Exam: _____

Last Name:		First Name/MI:		DOB:		Age:	
Address:			City:		State:		Zip:
Home Phone:		MRN:		Referring Physician:			
Could you be pregnant? <input type="checkbox"/> YES <input type="checkbox"/> NO							
Risk Factors: Personal history of breast cancer: <input type="checkbox"/>							
Family history of breast cancer:			<input type="checkbox"/> Mother	Approx. Age When Diagnosed: _____			
			<input type="checkbox"/> Sister 1	Approx. Age When Diagnosed: _____			
			<input type="checkbox"/> Sister 2	Approx. Age When Diagnosed: _____			
			<input type="checkbox"/> Daughter	Approx. Age When Diagnosed: _____			
Have you ever had a mammogram?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	If yes, when?			
		Where:					
Are you having any problems with your breast(s)?							
Have you ever had?							
1. A biopsy of your breast(s)?	<input type="checkbox"/> Right	or	<input type="checkbox"/> Left	When:			
2. A cyst aspiration (drainage)?	<input type="checkbox"/> Right	or	<input type="checkbox"/> Left	When:			
3. Mastectomy?	<input type="checkbox"/> Right	or	<input type="checkbox"/> Left	When:			
4. Lumpectomy?	<input type="checkbox"/> Right	or	<input type="checkbox"/> Left	When:			
5. Radiation Treatment?	<input type="checkbox"/> Right	or	<input type="checkbox"/> Left	When:			
6. Augmentation (implants)?	<input type="checkbox"/> Right	or	<input type="checkbox"/> Left	When:			
7. Breast Reduction?	<input type="checkbox"/> Right	or	<input type="checkbox"/> Left	When:			
Are you taking any hormones? <input type="checkbox"/> YES <input type="checkbox"/> NO				Number of years?			



Technologist Initials:		Ultrasound:	<input type="checkbox"/> Right or <input type="checkbox"/> Left
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