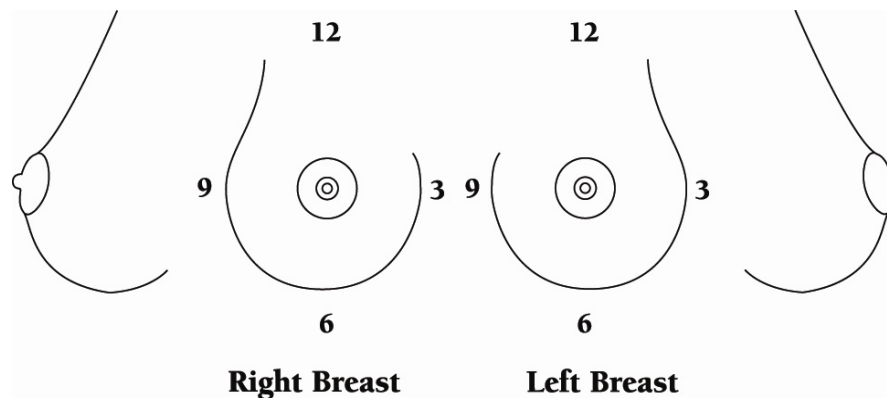


Date of Exam: _____

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"/> YES <input type="checkbox"/> NO Ovarian cancer: <input type="checkbox"/> YES <input type="checkbox"/> NO							
Family history of breast cancer:				Family history of ovarian cancer:			
<input type="checkbox"/> Mother	Approx. Age When Diagnosed: _____			<input type="checkbox"/> Mother	Approx. Age When Diagnosed: _____		
<input type="checkbox"/> Sister 1	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"/> Sister 2	Approx. Age When Diagnosed: _____		
<input type="checkbox"/> Daughter	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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