LAKESIDE WOMEN'S IMAGING
INTEGRIS NETWORK

Mammography History Form and Breast Cancer Risk Assessment

Due to changes in our mammography tracking system, please complete this form in its entirety to the best of your knowledge. Thank you for your cooperation during this transition and we apologize for the inconvenience.

Name _____ Date _____ Physician _____

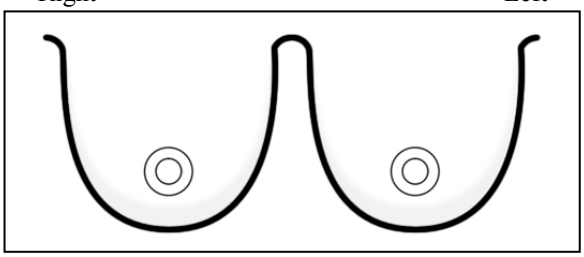
Age ___ DOB _____ Daytime Phone _____Previous Mammo Location _____

Today's mammogram is a ___ Baseline ___ 2D Screening ___ 3D Screening Tech _____

Do you have a NEW problem/concern? YES NO

	Right	Left
Lump You Can Feel	____	____
Breast Pain	____	____
Nipple Discharge	____	____
Nipple Inversion	____	____

Right Left



Hormone Therapy History:

Have you used Estrogen: YES NO Currently using? YES NO Years used from _____ to _____
Have you used Progesterone: YES NO Currently using? YES NO Years used from _____ to _____
Have you used Tamoxifen: YES NO Currently using? YES NO Years used from _____ to _____

Health/Personal History:

Current Height: _____ *Current Weight:* _____
Age of first Menses: _____ *Age of first live birth:* _____ *Age of Menopause:* _____ *Months Breastfeeding:* ____
Did you have radiation treatment to the chest between the ages of 10-30 for Hodgkin's disease? YES NO
Are you of Ashkenazi Jewish heritage? YES NO
Number of Maternal Aunts: _____ Number of Paternal Aunts: _____

Surgical History:

Hysterectomy? Yes No Date/Age: _____
Oophorectomy? Yes No Date/Age: _____
Previous Breast Surgery? Yes No Date/Age: _____ Right/Left: _____
Type of Breast Biopsy/Surgery? _____ Results? _____ Atypical Results? Yes No
Breast Implants? Yes No Date/Age: _____ ___Saline ___Silicone
Breast Reduction? Yes No Date/Age: _____
Have you been diagnosed with Breast Cancer? YES NO Age/Date: _____ Cancer Type: _____
Lumpectomy? Right/Left: _____ Date: _____ Mastectomy? Right/Left: _____ Date: _____
Radiation Therapy? Yes No Type: _____ Chemotherapy? Yes No

Do you have a family history of Breast or Ovarian Cancer? YES NO
If YES, please complete the following:

BREAST AND OVARIAN CANCER HISTORY	SELF		FAMILY		FAMILY MEMBERS: List only mother, father, siblings, children, grandparents, aunts, uncles, and first cousins		AGE AT DIAGNOSIS
					MOTHER'S SIDE	FATHER'S SIDE	
Breast cancer at age 50 or older *	Y	N	Y	N			
Breast cancer at age 50 or younger	Y	N	Y	N			
Ovarian cancer at any age	Y	N	Y	N			
Male breast cancer at any age	Y	N	Y	N			

Family member with triple negative breast cancer (receptor status negative for ER, PR and HER2) under the age of 60? YES NO
Do you have Pancreatic cancer with 2 or more breast and/or ovarian cancers on the same side of the family? YES NO
Do you have a family member with a BRCA mutation? YES NO
Have you been BRCA Tested? YES NO Results: _____