HIGH RESOLUTION | MEDICAL HISTORY FORM

Last Name: ______________________ First Name: ________________ Date of Birth: __________

Age: ________ Insurance: ______________________ Send copy of report to: ________________

Do you live within 60 miles of this facility? ☐ YES ☐ NO

Is this your first mammogram? ☐ NO ☐ YES If NO, when/where was your last mammogram? __________

Do you have implants? ☐ NO ☐ YES What type? __________ What year did you get them? ______

Answer the following questions, if applicable:

Age of 1st Menstruation: __________ # of Children Birthed: __________

Age of 1st Full Term Pregnancy: __________ # Breast Feed: __________

Menopause Age: __________ Years Smoked: __________

Age Ovaries Removed: __________ Patient Height: __________ Patient Weight: __________

Age of Hysterectomy: __________

	Date or Age Onset	**Date or Age Last Used**
Hormonal Contraceptives:	__________	__________
Estrogen:	__________	__________
Progesterone:	__________	__________
Anti-Estrogen Drug:	__________	__________

Last Menstrual Period: __________ Any chance of being pregnant? ☐ NO ☐ YES

Are you breastfeeding? ☐ NO ☐ YES

Personal breast cancer history? ☐ NO ☐ YES If YES, age of diagnosis? __________

Any history of radiation therapy or chemo for breast cancer? ☐ NO ☐ YES

Cancer elsewhere? ☐ NO ☐ YES If YES, what kind? __________

BRCA 1 or 2 gene mutation? ☐ NO ☐ YES

Family history of breast cancer? ☐ NO ☐ YES

Family history of ovarian cancer? ☐ NO ☐ YES

If YES, list maternal or paternal (mother or father), relationship (mother, aunt, etc.) and age of their diagnosis below:

Relationship to you	Maternal	Paternal	Age of diagnosis?	Breast or ovarian cancer?

Any NEW breast symptoms (lump, focal pain, clear/bloody nipple discharge)? ☐ YES ☐ NO

If YES, explain ______________________________

Have you had any breast surgeries/biopsies? ______________________________

If your history indicates High Risk and your Physician approves, do you want to be referred for an assessment? ☐ YES ☐ NO ________ initials

Notes: **Right** **Left**

Patient Signature: ______________________ **Date:** __________ **Technologist Initials:** ______

REV 11/15