CBIS Wilson

Mammography History Sheet

Patient ID ______ Site ID CBIS-W Patient's Age Date of Birth ______
Last ______ First ______ Middle ______
Referred By ______ Correspondence Language English (United States)

Please describe any new problems you are having with your breasts today. ______

Demographics

Phone ______ Ext ______ Type ______
Phone ______ Ext ______ Type ______
Address ______
City ______ State ______
Zip ______ Country ______
E-mail Address ______

☐ Send Correspondence via-Email

History of Cancer

Have you previously had any of the following cancers?

Cancer Type	at Age	Cancer Type	at Age
☐ Breast	______	☐ Endometrial	______
☐ Ovarian	______	☐ Other	______
☐ Colorectal	______		
☐ Newly diagnosed cancer			

______

Risk Factors

☐ No Known Previous Breast Biopsies ☐ No Known Family History of Cancer
☐ Ashkenazi Jewish ☐ Previously diagnosed with LCIS ☐ Previously diagnosed with DCIS

Have you been tested for any of the following cancer genes?

	Outcome
☐ BRCA1	______
☐ BRCA2	______

☐ Previous Chest Radiation Therapy at Age: ______
☐ Previous Chemotherapy at Age: ______
☐ Previously diagnosed with Atypical Ductal Hyperplasia at Age: ______
☐ Previously diagnosed with Atypical Lobular Hyperplasia at Age: ______
☐ Previously diagnosed with Hyperplasia without Atypia at Age: ______

Gynecological History

☐ Premenopausal ☐ Perimenopausal ☐ Postmenopausal

First Full-term Pregnancy at Age: ______ Hysterectomy at Age: ______ Menarche at Age: ______ Menopause at Age: ______
Left Ovary was Removed at Age: ______ Right Ovary was Removed at Age: ______ Number of Live Births: ______
Are you breast feeding? ☐Yes ☐No Last Menstrual Period ______ Last Clinical Breast Exam ______
Could you possibly be pregnant? ☐Yes ☐No

	Right Breast	Left Breast
Implant History	Implant date:	Implant date:
Implant Type	☐Saline ☐Silicone	☐Saline ☐Silicone
Implant Location	☐Pre-pectoral ☐Retro-pectoral	☐Pre-pectoral ☐Retro-pectoral

Breast Surgical and Treatment History (Include date, type and results and indicate left, right or both)

______

Hormone History

Have you ever used or are you currently using any of the following hormones?

Currently Using	Age at First Use	Age at Last Use	Duration Years	Duration Months	Intended Duration
☐ Hormonal Contraceptives	______	______	______	______	______
☐ Progesterone	______	______	______	______	______
☐ Raloxifene	______	______	______	______	______
☐ Estrogen	______	______	______	______	______
☐ Tamoxifen	______	______	______	______	______
☐ Unspecified	______	______	______	______	______

Patient: ______ Technologist: ______

Please Sign Above

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Please complete this page only if your family member(s) has(have) a history of breast, ovarian, pancreatic, uterine, prostate or colon cancer.

Family History

Has anyone in your family been diagnosed with cancer or been genetically tested for the cancer gene?

Relative: First Name: Middle Name:

Cancer Type ______ At Age ____ ☐ Unknown
Cancer Type ______ At Age ____ ☐ Unknown

Genetically Tested For: ____ Outcome: ____ Genetically Tested For: ____ Outcome: ____

Relative: First Name: Middle Name:

Cancer Type ______ At Age ____ ☐ Unknown
Cancer Type ______ At Age ____ ☐ Unknown

Genetically Tested For: ____ Outcome: ____ Genetically Tested For: ____ Outcome: ____

Relative: First Name: Middle Name:

Cancer Type ______ At Age ____ ☐ Unknown
Cancer Type ______ At Age ____ ☐ Unknown

Genetically Tested For: ____ Outcome: ____ Genetically Tested For: ____ Outcome: ____

Relative: First Name: Middle Name:

Cancer Type ______ At Age ____ ☐ Unknown
Cancer Type ______ At Age ____ ☐ Unknown

Genetically Tested For: ____ Outcome: ____ Genetically Tested For: ____ Outcome: ____

Relative: First Name: Middle Name:

Cancer Type ______ At Age ____ ☐ Unknown
Cancer Type ______ At Age ____ ☐ Unknown

Genetically Tested For: ____ Outcome: ____ Genetically Tested For: ____ Outcome: ____

Patient: Technologist:

Please Sign Above