PATIENT HISTORY FORM

PARTNERS IMAGING
WOMEN'S CENTERS

Name: _____

MRN: _____

DOB: _____ Age _____

When was your last mammogram?

_____

Where was your last mammogram?

_____

Current Symptoms

L = Left R= Right

L R
- ○ ○ Pain / Tenderness
- ○ ○ Lumps felt by patient / clinician
- ○ ○ Nipple discharge: clear or bloody
  How long? _____
- ○ ○ Breast infection / abscess
- ○ ○ Abnormal nipple? _____
- ○ ○ Other _____
- ○ None

Menstrual History

Last menstrual period _____

Hysterectomy? _____

Currently taking hormones? _____

Breast Cancer History

L R
- ○ ○ Lumptectomy Year _____
- ○ ○ Mastectomy Year _____
- ○ ○ Radiation Therapy
  Year completed _____
- ○ ○ Tram Flap Year _____
- ○ None

Previous Breast Treatment

L R
- ○ ○ Aspiration Year _____
  Results: ○ Negative ○ Positive
- ○ ○ Biopsy Year _____
  Results: ○ Negative ○ Positive
- ○ ○ Augmentation / Implants / Reduction
  Year: _____

Family History of Breast Cancer

	Breast	Ovarian
○ Mother age _____	○	○
○ Sister age _____	○	○
○ Daughter age _____	○	○
○ Grandmother age _____	○	○
○ Aunt age _____	○	○

- ○ Male members age _____
  Relation _____
- ○ BRCA Gene Mutation 1_____ 2 _____

Partners Staff Members Area

Patient visit date: _____

Partners tech name: _____

Date: _____