**PLEASE PRINT CLEARLY**

Hackensack Meridian *Health*

Date: ____/____/_____
Time: _____:_____

Patient Name: _____ Date of Birth: ____/____/_____
Last First MI

Sex: ○ Male ○ Female Height: _____ Weight:_____ Race:_____

Address: _____ City: _____ Zip: _____

Phone: (_____) _____-_____ E-Mail*: _____

Social Security: _____-____-_____ Preferred Language*: _____

Please list any allergies: _____

Are you experiencing any pain? ○ Yes ○ No Where? _____ Rate from 1-10 (1 is lowest) _____

**Do you have a NEULASTA PUMP? ○ Yes (You cannot have the exam until the pump is removed by your physician) ○ No**

**Do you have a FREESTYLE LIBRE FLASH GLUCOSE MONITORING SYSTEM or a DEXCOM G6 GLUCOSE MONITORING SYSTEM ?**
**○ Yes (You cannot have the exam) ○ No**

**☐ I have reviewed this form and acknowledge there are no changes to my medical history since my last exam**

**Signature: _____ Date: ____/____/_____**

## Mammography

Have you had previous mammograms? ○ Yes ○ No

If yes, when? ____/____/_____ Where? _____

**What is the REASON you are having a breast imaging exam (Please select one)?**

○ This is a routine (screening) exam. I am not having any breast problems
○ I have breast implants, but I am not having any problems
○ I am going to have a breast reduction ○ I have a known biopsy-proven malignancy
○ This is a short interval follow-up requested from my last exam (1-11 months ago)
○ I have a history of benign breast disease ○ This is a review of an outside study
○ This is an additional exam requested from an abnormal screening exam
○ This is an additional exam requested from a prior study done elsewhere
○ I have a personal history of breast cancer ○ with breast conservation therapy ○ with mastectomy
○ I am going to have radiation therapy ○ I have had breast radiation therapy
○ List any problems you are having (bloody discharge, cancer, large nodes, mass, etc.): _____

_____

_____

**Check all of the following RISK FACTORS that are true for you:**

☐ I do not know my personal breast cancer history ☐ I have had previous chest radiation therapy
☐ I have had breast cancer ☐ I have never had children ☐ I have BRCA1 gene mutation
☐ I have had ovarian cancer ☐ I had my first child after 30 ☐ I have BRCA2 gene mutation
☐ I have had endometrial cancer ☐ I have been through menopause
☐ I have had a previous biopsy that showed a high risk lesion

**Family breast cancer and ovarian cancer history:**

| Relationship (For example: Mother) | Age cancer developed | Breast or OVarian Cancer |
|---|---|---|
| | | |

**Menstrual History:**

Currently pregnant: ○ Yes ○ No Date of last menstrual period: ___/___/____ Age at menopause: _____

Age of first period: _____ Age at first full term pregnancy: _____ Age at hysterectomy: _____

Age at right ovary removal: _____ Age at left ovary removal: _____

Menstrual cycle phase, if applicable: ○ 1st week after ○ 2nd week after ○ 3rd week after ○ Presently in

**History of previous breast PROCEDURES (Breast reduction, cyst aspiration, core biopsy, excisional biopsy, implant removal, lumpectomy, masectomy, radiation therapy to the breast, reconstruction, other type of biopsy):**

| Procedure | Side (R or L) | Date Performed | Outcome |
|---|---|---|---|
| | | | |

**If you have IMPLANTS, indicate the type (for example: silicone gel, saline, combination) and/or location (for example: pre-pectoral, retro-pectoral) and the side:**

| Type | Location | Side |
|---|---|---|
| | | |

**Have you ever received chemotherapy for any type of cancer? ○ Yes ○ No ○ Not Sure**

**How many times do you perform breast self-examination per year?**

**○ Never ○ 1 - 3 Times ○ 4 - 8 Times ○ 9 - 15 Times ○ More Than 16 Times**

## DEXA/Bone Density

Reason for Exam: _____

Please answer ALL of the following questions:

1) Have you had a previous hip or vertebral fracture? ○ Yes ○ No
2) Have you had any fractures during your adult life which did not result from significant trauma? ○ Yes ○ No
3) Did either of your parents ever have a hip fracture? ○ Yes ○ No
4) Do you smoke? ○ Yes ○ No
5) Have you ever taken Glucocorticoids? ○ Yes ○ No
6) Do you have rheumatoid arthritis? ○ Yes ○ No
7) Do you have secondary osteoporosis? ○ Yes ○ No
8) Do you drink 3 or more alcoholic drinks per day? ○ Yes ○ No
9) Are you being treated for osteoporosis? ○ Yes ○ No
10) Have you ever taken any of the following medications?
☐ Actonel / risedronate ☐ Evista / raloxifene ☐ Fosamax / alendronate ☐ Miacalcin / calcitonin ☐ Vitamin D
☐ Reclast / zoledronate ☐ Boniva / ibandronate ☐ Forteo / parathyroid hormone ☐ Prolia / denosumab ☐ Multivitamin
☐ HRT (i.e. estrogen/hormone therapy) ☐ Protelos / strontium ranelate ☐ Calcium ☐ Other: _____
11) Do you have any of the following conditions? ☐ Anorexia / Bulimia ☐ End stage renal disease ☐ Hysterectomy
☐ Hyperparathyroidism ☐ Inflammatory bowel diseases ☐ Other (Please Specify): _____
12) What was your maximum height? _____
13) Do you perform weight bearing exercise regularly? ○ Yes ○ No
14) Do you regularly consume dairy products? ○ Yes ○ No
15) Do you drink caffeinated beverages? ○ Yes ○ No
16) Age of first period _____
17) How many full term pregnancies have you had? _____
18) Have you ever missed your period for more than 6 months in a row (not including pregnancy or menopau ○ Yes ○ No

**Signature: _____ Date: ____/____/_____**

**For Office Use Only Below This Line**

Equipment cleaned and disinfected prior to exam?

Technologist: _____