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 6G 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? _____

Method of refferal: ○ Letter of invitation ○ Other referral type ○ Verbal recommendation by my doctor

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

○ I am having the following PROBLEM(S) (Circle R for Right and L for Left):

☐ Bloody discharge	R	L	☐ Nipple problem	R	L
☐ Cancer elsewhere	R	L	☐ Pain in the breast	R	L
☐ Image detected calcifications	R	L	☐ Implant problem	R	L
☐ Large nodes under my arm	R	L	☐ Difficult physical exam	R	L
☐ Image detected mass	R	L	☐ Non-bloody discharge	R	L
☐ Other lump or thickening	R	L	☐ Palpable abnormality or lump	R	L
☐ Other skin changes to breast	R	L	☐ Skin thickening or retraction on clinical examination	R	L

If this is a screening exam, how long has it been since your last non-screening exam? _____

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

Hormone History:

Hormone	Never Used	Age at last Use	Currently Using
Hormonal contraceptives	☐		☐
Estrogen	☐		☐
Progesterone	☐		☐
Tamoxifen	☐		☐
Raloxifene	☐		☐
Arimidex	☐		☐
Other Hormones	☐		☐

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

Signature: _____ Date: ____/____/_____

For Office Use Only Below This Line

Equipment cleaned and disinfected prior to exam?
Technologist: _____