ChristianaCare

ENCBASFRM

BREAST IMAGING PATIENT HISTORY

Instructions:
1. Complete either side 1 or side 2.
2. **Draw a single line through the side that does not apply.**

Section I: To be completed by patient

☐ No ☐ Yes **Have you had a COVID-19 vaccine?**
Dose 1 date: _____ /_____ /_____ Manufacturer: ______________________ ☐ Right arm ☐ Left arm
Dose 2 date: _____ /_____ /_____ Manufacturer: ______________________ ☐ Right arm ☐ Left arm
Booster date: _____ /_____ /_____ Manufacturer: ______________________ ☐ Right arm ☐ Left arm

☐ No ☐ Yes **Have you ever had a mammogram?** Where: ______________________ Year: _________

☐ No ☐ Yes **Are you having any problems with your breasts today?**
Reason for today's exam: ______________________

☐ No ☐ Yes Are you currently pregnant?
☐ No ☐ Yes Are you currently breastfeeding?
☐ No ☐ Yes Have you had significant weight loss?
☐ No ☐ Yes Are you currently taking hormones?

☐ No ☐ Yes **Have you ever had a benign (not cancer) breast biopsy?**
Year: _________ ☐ Right ☐ Left Diagnosis: ______________________
Year: _________ ☐ Right ☐ Left Diagnosis: ______________________

☐ No ☐ Yes **Have you ever been diagnosed with BREAST cancer, including Ductal Carcinoma in Situ (DCIS)?**
Year: _________ ☐ Right ☐ Left
Treatment: ☐ Lumpectomy ☐ Mastectomy ☐ Radiation ☐ Chemotherapy ☐ Hormone therapy
Year: _________ ☐ Right ☐ Left
Treatment: ☐ Lumpectomy ☐ Mastectomy ☐ Radiation ☐ Chemotherapy ☐ Hormone therapy

☐ No ☐ Yes **Have you ever had cosmetic breast surgery?**
☐ Augmentation (implants) ☐ Reduction ☐ Lift ☐ Flap reconstruction ☐ Other: ___________

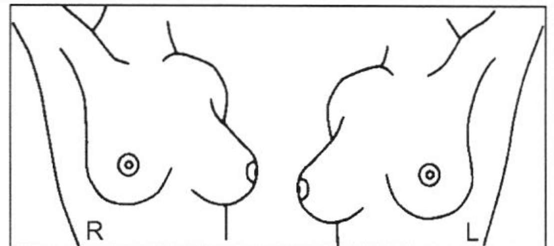
☐ No ☐ Yes **Have you ever been diagnosed with ANY type of cancer?** Type: ______________ Year: _________

☐ No ☐ Yes **Do you have a family history of breast and/or ovarian cancer?**
Type of cancer: ______________ Relation to you: ______________ Age when diagnosed: _____
Type of cancer: ______________ Relation to you: ______________ Age when diagnosed: _____

☐ No ☐ Yes **Do you have a tattoo?** If yes, specify location: ______________________

Patient/Representative Signature	Relationship to Patient	Date ___/___/___	Time

Section II: To be completed by technologist



Technologist Signature/Title	Print Name or ID#	Date ___/___/___	Time

Interpretation: The information has been presented to the: ☐ Patient ☐ Representative ☐ Decision Maker in: ___________ (Language)
The person who provided the interpretation is a qualified medical interpreter.

Interpreter Name	Agency and ID# (if applicable)

Witness Signature/Title	Print Name or ID#	Date ___/___/___	Time