Barnabas Health Ambulatory Care Center

RWJBarnabas HEALTH

Name: _____ Date of Birth: _____ Age: _____

Would you like your results sent via e-mail? ☐ Yes *or* ☐ No

If yes, please provide us with your email address: _____

Reason for today's mammogram/ultrasound/MRI: ☐ Routine *or* ☐ Problem: _____

eg. lump, discharge, pain, etc.

Have you ever had a mammogram/breast ultrasound/breast MRI here? ☐ Yes *or* ☐ No

If not here, when and where? _____

Date of Last Menstrual Period: _____ / _____ / _____ *It is recommended to have a screening breast MRI between days 7-14 of your menstrual cycle since this improves visualization of any abnormalities which may be otherwise hidden.*

Could you be pregnant? ☐ Yes ☐ No

Are you breast feeding? ☐ Yes ☐ No

# of Children | |

breast fed | |

	Age	Year
1st Menstruation		
1st Full Term Pregnancy		
Last Pregnancy		
Menopause		

Height: | |

Weight: | |

Have you ever used:

	NO	If YES, how long?	Still Using?
Hormonal Contraceptives?			
Hormonal Therapy? *(for menopausal symptoms)*			

Do you smoke? ☐ Yes *or* ☐ No

If YES, for how long? _____

Do you have a family history of breast cancer?

☐ Yes *or* ☐ No *or* ☐ Unknown

Ashkenazi Jewish heritage? ☐ Yes *or* ☐ No

BRCA gene mutation? ☐ Yes *or* ☐ No

Relatives with breast cancer: *Check all that apply & enter age at diagnosis*

1st degree relatives ☐ Mother _____ ☐ Father _____ ☐ Child _____

2nd degree relatives ☐ Sibling _____ ☐ Grandparent _____

Other ☐ Cousin _____ ☐ Aunt _____ ☐ Uncle _____

Surgical Breast History:	**RIGHT (year)**	**LEFT (year)**	**Details**
Implants			☐ Silicone or ☐ Saline / Behind Muscle? ☐ Yes *or* ☐ No *or* ☐ Unsure
Reduction or Lift			
Benign Surgical Biopsy			What was it?
Biopsy Showing Atypia			
Biopsy Showing LCIS			
Breast Cancer			☐ in situ or ☐ Invasive? / ☐ Lumpectomy or ☐ Mastectomy?
Axillary Surgery			☐ Sentinel node procedure or ☐ Full axillary dissection?
Radiation			

Chemotherapy ☐ Yes *or* ☐ No

Tamoxifen ☐ Yes *or* ☐ No

Aromatase Inhibitor ☐ Yes *or* ☐ No

(Femara, Arimidex, Aromasin)

Allergies: ☐ None ☐ CT Contrast ☐ MRI Contrast ☐ Medications _____ ☐ Latex

Signature of Patient _____ Date _____

QB12097 (2/17)