HDI
High Desert Imaging

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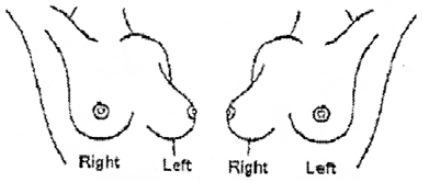
Breast Imaging Patient History

MRN#:

Patient: | Contact #'s | DOB: Age:
Day: | Appt Time:_____
Home | Event Date: _____
MD:_____ | Cell: | Clerk:____ _____

Tech Initials: _____

☐ Screening ☐ Diagnostic ☐ R ☐ L ☐ Bilateral
☐ Ultrasound ☐ R ☐ L ☐ Bilateral
Views: Std._____ Other: _____
Tech Notes:
_____



Current Complaints/symptoms

Left/Right/Both – Explain

Lump _____ _____
Pain _____ _____
Tenderness _____ _____
Discharge _____ _____
Other _____ _____

Breast Surgical and Treatment History

	Let/Right/Both – Date	
Aspiration	_____	_____
Needle biopsy	_____	_____
Surgery (non cancer)	_____	_____
Stereo biopsy	_____	_____
Reconstruction	_____	_____
Reduction	_____	_____
Lumpectomy (for cancer)	_____	_____
Mastectomy	_____	_____
Radiation therapy	_____	_____
Chemo therapy	_____	_____

Family History of Breast/Ovarian Cancer

	Age	*Age Before 50?*
Self	_____	☐
Mother	_____	☐
Daughter	_____	☐
Sister	_____	☐
Grandma (maternal)	_____	☐
Grandma (paternal)	_____	☐
Aunt (maternal)	_____	☐
Aunt (paternal)	_____	☐
2 or more over the age of 50?:	☐ Yes	☐ No
Any history of male breast cancer?	☐ Yes	☐ No
Any family history of ovarian cancer?	☐ Yes	☐ No
Are you of Ashkenazi Jewish heritage?	☐ Yes	☐ No

Additional Patient Information

If you've had breast cancer, how was it found?
☐ Mammogram – mass
☐ Mammogram – calcification
☐ Palpable lump
☐ Not sure

Left/Right/Both - Date

Do you have breast implants? _____ _____
Are you currently on hormones? ☐ Yes ☐ No
Are you interested in genetic testing, if you qualify? ☐ Yes ☐ No
Have you previously been offered testing? ☐ Yes ☐ No

Have you had a weight change of 10 lbs, more or less, since your last mammogram?
☐ None ☐ Gain ☐ Loss ☐ How Much?
Is this your first mammogram? ☐ Yes ☐ No How long since your last mammogram? _____yrs _____mos
At what facility was your last mammogram performed? : _____

The above information is correct and I authorize the release of my prior mammograms to this facility.

Patient Signature:_____ Date:_____