Patient Demographic Sticker

St. Anthony Breast Center
Centura Health

Is there any possibility that you are pregnant? ☐ Yes ☐ No How did you hear about us? _____
Best phone # to contact you: _____ Can we leave a voice message regarding normal results? ☐Yes ☐No
If you are not available, can we leave a message with whoever answers the phone? ☐ Yes ☐ No

PREVIOUS MAMMOGRAM:

☐ Yes ☐ No Location: _____ Date: _____
☐ Yes ☐ No Have you had an abnormal mammogram in the last year?

REASON FOR EXAM:

☐ Routine ☐ Problem
☐ Yes ☐ No Any **NEW** problems such as a lump, thickening or nipple discharge? If yes, Please describe
Right_____ Left_____
_____ _____

BREAST SURGERY HISTORY:

☐ Yes ☐ No Breast Implants Left_____ Right_____ Date: _____
☐ Yes ☐ No Breast Reduction Left_____ Right_____ Date: _____
☐ Yes ☐ No Needle Biopsy Left_____ Right_____ Date: _____
☐ Yes ☐ No Surgical Biopsy Left_____ Right_____ Date: _____
☐ Yes ☐ No Have you ever been diagnosed with breast cancer? Please check all that apply:
Lumpectomy ☐ Left ☐ Right Date: _____
Mastectomy ☐ Left ☐ Right Date: _____ ☐Radiation ☐Chemotherapy

MEDICAL HISTORY:

Do you smoke? ☐Yes ☐No ☐Past hx of smoking Stopped _____ yrs / months ago
Age at 1st period _____ Age at 1st child _____ # of pregnancies _____ # of live births _____
Age at menopause: _____ Age at hysterectomy: _____ ☐ Partial ☐ Complete
Hormone Replacement Therapy? ☐Yes ☐No ☐ Current user ☐ Never
Length of use: _____ yrs / months Stopped _____ yrs/months ago

Have you ever been diagnosed with: ☐ Atypical Hyperplasia ☐ LCIS ☐ Ovarian cancer
☐Yes ☐No Previous chest radiation (mantel radiation for thyroid or lymphoma)? If YES, age_____
☐Yes ☐No **ANY** other cancer? If YES, what type? _____ Age _____

FAMILY HISTORY OF CANCER:

Please indicate any of your relatives that have been diagnosed with breast cancer or ovarian cancer:

RELATIVE	Circle: RELATED **FROM WHAT SIDE OF FAMILY**	Circle: **TYPE OF CANCER**	AGE DIAGNOSED
	Mother's / Father's	Breast / Ovarian	
	Mother's / Father's	Breast / Ovarian	
	Mother's / Father's	Breast / Ovarian	
	Mother's / Father's	Breast / Ovarian	
	Mother's / Father's	Breast / Ovarian	

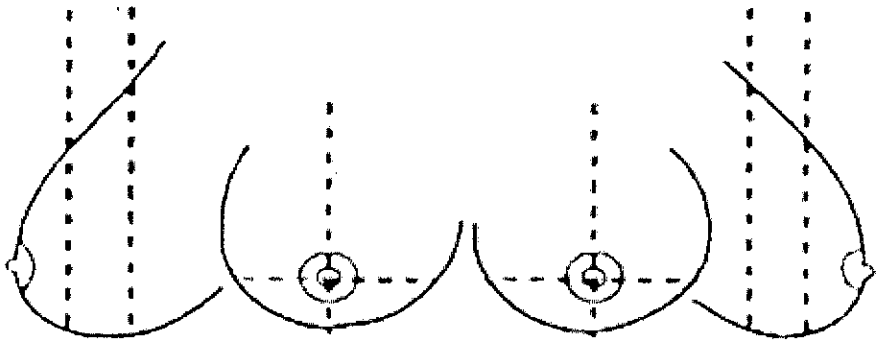
Are you of Eastern European (Ashkenazi) Jewish ancestry? ☐Yes ☐No
Have you or any member of your family had genetic testing? ☐Yes ☐No
If yes, what genetic test, who underwent testing, and what were the results? _____

PLEASE READ AND SIGN BELOW:

1. I understand that mammography cannot detect all breast cancers. I understand that I should have yearly examinations by my doctor in addition to undergoing mammography and performing breast self-examinations.
2. This facility is required by the FDA to audit mammography outcomes. To help accomplish this, I give my permission to St. Anthony Hospital to give or receive medical information and to give or receive mammography films to/from other physicians and medical facilities involved in my care.
3. Follow up diagnostic studies and treatments vary depending on individual radiographic evaluation and clinical situations. I understand that it is my obligation to follow my referring doctor's advice concerning follow up diagnostic studies, biopsies or therapy.

Patient's Signature: _____ Date: _____

TO BE FILLED OUT BY TECHNOLOGIST AND PHYSICIAN



Technologist: _____ Date: _____

Comments:

_____

_____

_____

_____

_____

_____

IBIS Personal Lifetime Risk _____%

☐ Thoracic Radiation _____ Age

☐ Please contact patient for Genetic Counseling

☐ Patient will contact you for Genetic Counseling