LAKESIDE WOMEN'S IMAGING
INTEGRIS NETWORK

COVID Vaccine: ☐ Yes ☐ No
FLU Vaccine: ☐ Yes ☐ No
LEFT RIGHT arm
Date of Last dose:_____

Name _____ Date _____ Physician _____

Age _____ DOB _____ Daytime Phone _____ Previous Mammogram Location _____

Is this a routine screening (no symptoms)? ☐ YES ☐ NO ☐ Baseline Exam Technologist _____

Vitals: **Weight** _____ **Height**_____

Hormone History: Please fill out all **current and past** hormone usage

Birth Control:	Currently using? ☐ YES ☐ NO	Start date _____	Stop date _____
Estrogen:	Currently using? ☐ YES ☐ NO	Start date _____	Stop date _____
Progesterone:	Currently using? ☐ YES ☐ NO	Start date _____	Stop date _____
Tamoxifen:	Currently using? ☐ YES ☐ NO	Start date _____	Stop date _____

Gynecologic History:

Your age at 1st period _____ Age at birth of 1st child _____
Age at Menopause _____
Age at Hysterectomy _____ Age Ovaries Removed _____

Do YOU have a Personal history of:

☐ Atypical hyperplasia
☐ Breast cancer/DCIS
☐ Lobular carcinoma in Situ (LCIS)
☐ Ovarian Cancer
☐ Genetic mutation: ☐ BRCA 1 ☐ BRCA 2
☐ Ashkenazi Jewish heritage
☐ Chest radiation between age 10-13 (ex: Hodgkin's disease)

Family Cancer History: ☐ NO

Relative	Breast	Ovarian	Age at Diagnosis
Mother	☐	☐	_____
Sister	☐	☐	_____
Daughter	☐	☐	_____
Maternal Grandmother	☐	☐	_____
Paternal Grandmother	☐	☐	_____
Maternal Aunt	☐	☐	_____
Paternal Aunt	☐	☐	_____
Maternal Cousin	☐	☐	_____
Paternal Cousin	☐	☐	_____
Maternal Grandfather	☐	☐	_____
Paternal Grandfather	☐	☐	_____

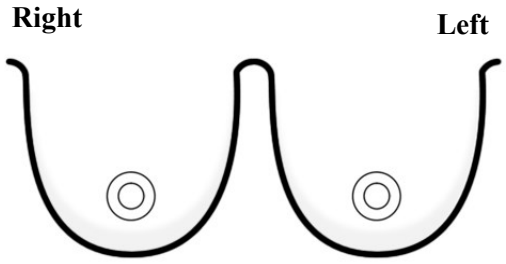
Other _____

Personal Breast Surgical /Treatment History

Breast biopsy R L Both Date _____
Reduction Date _____
Implants Date _____ ☐ Silicone ☐ Saline
Lumpectomy/Cancer R L Both Date _____
Mastectomy R L Both Date _____
Radiation ☐ Yes
Chemotherapy ☐ Yes

NEW Breast Concerns /Problems: ☐ YES ☐ NO

Lump You Can Feel	R	L
Breast Pain	R	L
Nipple Discharge	R	L
Nipple Inversion	R	L



Comments:

_____
_____
_____
_____
_____