# RALEIGH RADIOLOGY BREAST HISTORY FORM

NAME: _____ DATE OF BIRTH: _____ AGE_____

DATE OF LAST MENSTRUAL CYCLE: _____ ARE YOU POST-MENOPAUSAL: YES NO

COVID VACCINE: YES NO ARM: LEFT RIGHT DATE OF VACCINE: _____

DATE OF LAST MAMMOGRAM AND LOCATION: _____

PRIOR BREAST MRI? YES NO DATE AND LOCATION: _____

REASON FOR TODAY'S BREAST MRI? _____

DO YOU HAVE A HISTORY OF ANY CANCER? YES NO

-IF YES, WHAT TYPE AND YEAR OF DIAGNOSIS?

_____

HAVE YOU EVER HAD A BREAST BIOPSY? YES NO

-IF YES WHICH SIDE(S) AND WHAT YEAR(S)?

_____

-WHAT WERE THE FINDINGS?

_____

HAVE YOU EVER HAD BREAST SURGERY? YES NO

-IF YES WHICH SIDE(S) AND WHAT YEAR(S)?

_____

FAMILY HISTORY OF BREAST CANCER? YES NO

-IF YES, WHICH FAMILY MEMBERS AND THEIR AGE AT DIAGNOSIS?

_____

HAVE YOU HAD POSITIVE GENETIC TESTING? YES NO

-IF YES, PLEASE LIST WHICH TEST WAS POSITIVE

_____

DO YOU HAVE BREAST IMPLANTS? YES NO

TYPE OF IMPLANTS? SILICONE SALINE BOTH UNSURE

HAVE YOU HAD CHEMOTHERAPY? YES NO LAST SESSION DATE: _____

HAVE YOU HAD RADIATION? YES NO LAST SESSION DATE: _____

TECHNOLOGIST SIGNATURE: _____Date: _____