PALMS IMAGING CENTER

Setting the standard for service, commitment & accuracy.

Breast Screening Form

Patient's Name: _____

Date of Birth: _____/_____/_____ Age: _____ Weight: _____

Location of Last Mammogram: _____

Were there any other studies done (i.e. ultrasound, etc.): _____

Reason for exam: _____

Do you have a family history of breast cancer: ☐ Yes ☐ No If yes, whom: _____

Have you had a breast biopsy: ☐ Yes ☐ No

If yes, where: _____

Have you had breast surgery: ☐ Yes ☐ No

If yes, where: _____

Beginning date of last menstrual cycle: _____

Pregnant: ☐ Yes ☐ No

Breast Feeding: ☐ Yes ☐ No

Have you had any chemotherapy treatment for the breast: ☐ Yes ☐ No

If so, when was your last treatment: _____

Have you ever had Radiation treatment of the breast: ☐ Yes ☐ No

If so, when was your last treatment: _____

Are you on any type of hormone medication (i.e. estrogen, etc.): ☐ Yes ☐ No

If so, what type: _____

BREAST IMPLANTS: ☐ Yes ☐ No

TYPE OF IMPLANT: ☐ Saline ☐ Silicone

Make of implant: _____

Catalog Model #: _____

Signature: _____ Date: _____

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