ZILKHA RADIOLOGY

369 East Main Street; Suite 18; East Islip, NY 11730-2800 Tele (631) 277-1600 Fax (631) 277-1638
1161 Montauk Highway; West Islip, NY 11795-4930 Tele (631) 669-1717 Fax (631) 669-0854

Patient Medical History for Breast Imaging

Date _____ **Chart #:** _____

Patient Name: _____ **Date of Birth:** _____

Reason why your doctor ordered this test? _____

Date of Last Mammogram _____Place _____
(It is the responsibility of the patient to bring prior mammograms from other facilities for comparison purposes)

Date YOUR doctor last examined YOUR breasts: _____ Results: _____

Please indicate which close family member, if any, has had breast cancer and the age it was discovered? **NONE**

Mother _____ **Sister(s)** _____ **Daughter(s)** _____ **Father** _____

Please indicate if you **currently** have:

Symptoms	Right	Left	Duration & Description
Pain or Tenderness			
Lump or Thickening			
Discharge or Bleeding			

Please note; if you are here for your annual screening and you have symptoms this is no longer a screening mammogram and a copayment, deductible or co-insurance may be applied.

Please indicate if you have had:

Medical History/Surgery	Right – Date(s)	Left – Date(s)
Breast Implants		
Reduction Surgery		
Surgical Biopsy		
Breast Cancer		
Radiation Therapy		
Lumpectomy		
Mastectomy		

Any chance you are pregnant? **YES** **NO** Are you currently nursing? **YES** **NO**

Age of your first menstrual period? _____

Do you still menstruate? **YES** **NO** If **YES**, start date of your LMP? _____

Has your weight changed significantly since your last mammogram? **GAINED** **LOST** Amount _____

I hereby state that the information listed above is accurate to the best of my knowledge.

Patient or Legal Guardian Signature _____ **Date**_____