PERSONAL AND FAMILY HISTORY

NAME: _____ **TODAY'S DATE:** _____

PATIENT'S PERSONAL RISK FACTORS	☐ **Yes (please indicate below)**		☐ **None**	
☐ History of breast cancer		☐	☐	☐ Right ☐ Left
☐ History of ovarian cancer		☐	☐	
☐ Previous chest radiation therapy		☐	☐	

DO YOU HAVE A FAMILY HISTORY OF BREAST & OVARIAN CANCER? ☐ **Yes** ☐ **No**				
If yes: Blood Relatives: (Mom, Sister, Daughter, Aunt, Grandmother, Cousin, Father, Brother, Son, Grandfather, Uncle)	**Maternal or Paternal**	**At Age**	**Under 50**	**Over 50**
			☐	☐
			☐	☐
			☐	☐

Last menstrual period:_____ **First menstrual period at age**_____ **First full-term pregnancy at age**_____

ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING: ☐ **Yes (please indicate)** ☐ **No**

☐ Birth Control Pills ☐ Hormones ☐ Cortisone **FOR HOW LONG?**

BREAST IMPLANTS? ☐ **Yes** ☐ **No**	
If Yes, Procedure Date	Silicone, Saline, Combination (indicate)

PREVIOUS BREAST SURGERY? ☐ **Yes** ☐ **No**			
Type of Surgery	Procedure Date	Right or Left	Findings

LIST DOCTOR(S) THAT YOU WANT YOUR REPORT SENT TO. (*If not an OGMC doctor, please give doctor's full name and mailing address and/or phone number)*

_____

_____

AT THE PRESENT TIME, DO YOU HAVE ANY OF THE FOLLOWING PROBLEMS: ☐ **Yes (indicate)** ☐ **No**	RIGHT BREAST	LEFT BREAST
☐ New lump(s) in your breast	☐	☐
☐ Pain	☐	☐
☐ Discharge from nipple	☐	☐
☐ Warts or moles	☐	☐
Other breast problem(s), please indicate:		

DATE OF PREVIOUS MAMMOGRAM: _____ **LOCATION:** _____

PLEASE READ AND SIGN:

You will receive a result letter in the mail within one week. A copy of your report will also be sent to the physician(s) listed above. If there are any further questions regarding your results, you should contact your physician.

Even though the amount of radiation received from Mammograms is very small, there is a possibility of harm from radiation to the unborn child. Therefore, you should NOT undergo this procedure if you are pregnant. I am not pregnant or breast-feeding.

SIGNATURE: _____