Abercrombie Radiology

DATE: _____ FILM # _____

NAME: _____ ____ / ____ / ____ AGE _____
Date of Birth

PHYSICIAN: _____
List names of all doctors you want copy of reports to go to.

CIRCLE ONE

1. Do you have any new symptoms such as a mass or hard knot in your breast? YES NO
   Bloody nipple discharge? Skin or nipple indentation?
   If yes, describe _____
   _____
2. Did your doctor feel something? Where? _____ YES NO
3. Have you had breast cancer? YES NO
4. Do you have implants or have had breast reduction? YES NO
5. Are you under age 35? YES NO

6a. Have you had a mammogram in the past 6 months? YES NO

6b. Do you have previous mammograms? YES NO
   When? _____ Where? _____

7. Have you had a breast MRI? YES NO
   When? _____ Where? _____
8. Could you be pregnant? YES NO
9. Are you taking hormones? YES NO
   If so, how long? _____

BREAST CANCER RISK ASSESSMENT

1. Family history of breast cancer in a first degree relative (mother, sister, daughter)? YES NO
   ❑ Mother _____ ❑ Sisters(s) _____ ❑ Daughter(s) _____
   Age at diagnosis Age(s) at diagnosis Age(s) at diagnosis
2. Have you had breast surgery or needle biopsy? If so, which breast? _____ YES NO
   Were any of these atypical hyperplasia? YES NO
3. At what age did you have your first period? _____
4. At what age did you give birth to your first child? _____
5. What is your race/ethnicity? _____
6. Are you taking Tamoxifen? YES NO
7. Have you had a breast biopsy showing LCIS? (lobular carcinoma in situ) YES NO
8. Have you used birth control pills? YES NO
   If yes, at what age did you start? _____ At what age did you stop? _____

PATIENT SIGNATURE _____

FOR OFFICE USE ONLY

Breast Density:

- ❑ **<25% Almost entirely fatty**
- ❑ **25 – 49% Scattered fibroglandular density**
- ❑ **50 – 74% Heterogeneously dense**
- ❑ **75 – 100% Extremely dense**

Lifetime Risk (to Age 90) _____ %

DIAGNOSTIC EXAMINATION

Note: Technologist mark scars, moles, or if nipple inverted or everted.

TECHNOLOGIST SIGNATURE **RADIOLOGIST SIGNATURE**