CNY DIAGNOSTIC IMAGING

a Rezolut partner

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BREAST HISTORY

Office Use Only: GAIL SCORE
Lifetime Risk _______ 5 YR Risk _______

Name:

Date of Birth: Age: Referring Physician:

RACE/ETHNICITY

❏ White
❏ African American
❏ Ashkenazi Jewish Heritage
❏ Asian or Pacific Islander
❏ Unknown
❏ Hispanic
❏ American Indian or AK Native

PERSONAL HISTORY

Are you pregnant? ❏ Yes ❏ No

Last clinical breast exam: ____________________

Date of last menstrual period: ________________

Age of first period: ____________________________

Age of first pregnancy: _______________________

Number of births: ____________________________

Are you currently using hormones? ❏ Yes ❏ No

Are you currently using contraceptives? ❏ Yes ❏ No

History of Hodgkin's Lymphoma? ❏ Yes ❏ No

If yes, radiation treatment: ❏ Yes ❏ No

Age diagnosed: ______________________________

CURRENT BREAST PROBLEMS

❏ NONE ❏ Right ❏ Left
❏ Lump ❏ Right ❏ Left
❏ Tenderness/Pain ❏ Right ❏ Left
❏ Nipple Secretion

Color: ____

PREVIOUS MAMMOGRAMS

❏ NONE

Date of last mammogram: ________________________

Where performed: ________________________________

BREAST IMPLANTS

❏ Yes ❏ No

PREVIOUS GAMMAGRAM OR BREAST MRI

❏ NONE

Date of last GAMMA or breast MRI: ________________

Where performed: _______________________________

RISK FACTORS

If adopted do you know natural family history? ❏ Yes ❏ No ❏ N/A

Have you had breast or ovarian cancer? ❏ Yes ❏ No ❏ If Yes, specify: ____

Family history of breast and/or ovarian cancer ONLY:

	Current age or age deceased	Age diagnosed	Breast Cancer	Ovarian Cancer	Deceased
❏ NONE	_________	_________	❏	❏	❏
❏ Mother	_________	_________	❏	❏	❏
❏ Sister	_________	_________	❏	❏	❏
❏ Daughter	_________	_________	❏	❏	❏
❏ Grandmother	_________	_________	❏	❏	❏
❏ Aunt	_________	_________	❏	❏	❏
❏ Cousin (1st degree)	_________	_________	❏	❏	❏

	Current age or age deceased	Age diagnosed	Breast Cancer	Deceased
❏ Father	_________	_________	❏	❏
❏ Brother	_________	_________	❏	❏
❏ Son	_________	_________	❏	❏
❏ Grandfather	_________	_________	❏	❏
❏ Uncle	_________	_________	❏	❏

Have you or a family member been tested for the breast cancer gene (BRCA 1 or BRCA 2)? ❏ Yes ❏ No

BREAST SURGERY OR BIOPSY

❏ NONE

	Side	Date	Positive	Negative
❏ Biopsy	❏ Right ❏ Left	Date ____________________________	❏	❏
❏ Lumpectomy (benign)	❏ Right ❏ Left	Date ____________________________	❏	❏
❏ Lumpectomy (cancer)	❏ Right ❏ Left	Date ____________________________	❏	
❏ Lumpectomy (w/radiation)	❏ Right ❏ Left	Date ____________________________	❏	
❏ Mastectomy	❏ Right ❏ Left	Date ____________________________		
❏ Reduction	❏ Right ❏ Left	Date ____________________________		

Patient Signature: Date: _______ / _______ / _______

REV 1/2023