

Social Security Number _____
 Chart Number _____
 Date of Birth _____
 Study Date _____
 Gender: Female Male
 Last Name _____
 First Name _____
 Middle Init. _____ Maiden Name _____
 Street Address: _____
 Street Address: _____
 City _____ County _____
 State _____ Zip Code _____
 Phone Number (____) _____

Check all that apply to your racial/ethnic identity:

- Black Hispanic/ Latin
 White Other _____
 Asian
 American Indian: What tribe? _____

What is the highest level of education you have completed?()

- Less than high school
 High school/GED
 Some college
 College grad. or post college grad.

Have you had a previous mammogram?

- Yes No Don't know
 If yes, when (date)? _____

Was it done at this facility or at another facility?

Please name the facility _____

Have you been diagnosed with breast cancer?

- No
 Yes, Left Right Both

What month and year were you first diagnosed? _____

Has your mother, sister, or daughter had breast cancer?

Check all that apply.

Mother: No Yes At age: _____

Sister: No Yes At age: _____

Daughter: No Yes At age: _____

Have you had previous breast biopsies or surgery?

If yes, please the chart below and include date(s) of the procedures.

	Left		Right	
	<input checked="" type="checkbox"/>	date*	<input checked="" type="checkbox"/>	date*
Cyst Aspiration				
Surgical Biopsy				
Needle Biopsy				
Mastectomy				
Lumpectomy				
Radiation Therapy				
Breast Implants				
Other Procedure				

*Please fill in as much of the date as you know (month, day, or year)

Have you had breast problems in the past 3 months?

- Yes No

If yes, please fill in the chart with a below:

	Left	Right	Both	Comments
Lump				
Discharge				
Pain				
Other				

Did you make this appt. as a result of these problems?

- Yes No

What is your current height? Ft/inches _____

What is your current weight? Lbs. _____

Are you currently taking hormones?

- No Yes, year you began _____

Please the hormone you take:

- Tamoxifen/ Raloxifene Oral Contraceptives
 Hormone replacement Other
 Natural/Herbal hormone Don't Know

Have you had Hysterectomy surgery? Yes No

If yes, when (date)? _____

Have your ovaries been removed?

- Yes No Don't know

Have your regular periods stopped?

- No, my last menstrual period began _____
 Yes, they stopped naturally
 Yes, naturally, but have them now from taking hormones
 Yes, they stopped after surgery
 Yes, other reason
 Not sure, they are less frequent

Is your insurance paying for this visit?

- Yes
 No, I am paying for this visit out of my own funds
 Don't know

If yes, please which insurance:

- Medicare other _____
 Medicaid BCCCP