Teton Radiology
advanced medical imaging

BREAST CARE WORKSHEET

Patient Name:_____ DOB:_____ MR#_____

First mammogram: ☐Yes ☐No

If No: Date and Location of last mammogram if not at Teton Radiology: _____

_____

Ashkenazi Jewish Ancestry: ☐ Yes ☐ No

First menstrual period @ age:_____ Menopause @ age:_____

First full term pregnancy @ age:_____ Number of live births:_____

Hysterectomy @ age:_____ Left ovary removed @ age:_____ Right ovary removed @ age:_____

Are you Pregnant: ☐Yes ☐No ☐Unsure

Have you ever been diagnosed with breast cancer: ☐Yes ☐No

Family history breast cancer: ☐No ☐Mother ☐Grandmother M/P ☐Aunt M/P ☐Sister ☐Daughter ☐Cousin M/P

Male Family history breast cancer **(*circle*):** Father / Brother / Son / Nephew / Uncle

Breast Implants: ☐ Yes ☐ No ☐ Bilateral ☐ Right ☐ Left Type: ☐ Saline ☐ Silicone ☐ Unsure

Hormone medications: ☐Yes ☐ No If **Yes** what type:_____Increase or Decrease from last mammogram_____

Weight changes since last mammogram: ☐Yes ☐ No If Yes ***(circle)***: Increase / Decrease Amount of change:_____

Current breast concerns:_____

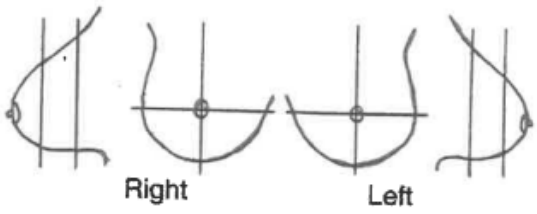
Breast surgical history:_____

Vaccines of all types can result in temporary swelling of the lymph nodes, which may be a sign that the body is making antibodies in response as intended.
Have you had the Covid Vaccine? Yes / No Date of Vaccination:_____ Arm: Left / Right

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and I have had the opportunity to ask questions regarding the information on this form. I understand that by signing this form I am giving Teton Radiology my consent to treatment.

Signature of person completing form:_____Relationship:_____ Date:_____

CLINICAL USE



RT Comments:_____
_____
_____
_____

Risk: _____

Revised 7/15/2022