INNOVACARE LLC

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MEDICAL HISTORY FOR BREAST DIAGNOSTIC EXAMINATION

Name _____ Date_____

Your Doctor's Full Name:

_____

Date of Birth: _____ Have you had a previous mammogram? Yes____ No____

Have you had a hysterectomy? Yes_____ No_____

Have you ever taken birth control pills or hormone replacement? Yes_____ No_____

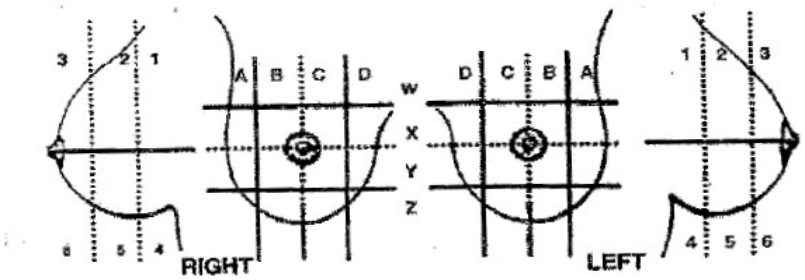
Has anyone in your family had breast cancer? Yes____ No____ ;
If yes, what relationship to you?_____

Please answer the following questions about your breasts:

	NO	Right	Left
Lumps in breast	❑	❑	❑
Discomfort, pain, soreness	❑	❑	❑
Discharge from nipple	❑	❑	❑
Previous breast surgery	❑	❑	❑
Biopsy	❑	❑	❑
Mastectomy	❑	❑	❑
Moles	❑	❑	❑
Do you have breast implants?	❑	❑	❑

Notes:_____

_____



WOMEN'S DIAGNOSTIC CENTER