John T. Mather Memorial Hospital • 75 North Country Road, Port Jefferson, N.Y. 11777

Patient Label

BC5730

Name _____ Home Phone _____
Address _____ Cell Phone _____
Date of Birth _____
Doctor who you have recently seen to send results _____
Is this your first mammo _____ Date & Location of your last mammo _____
Date of last clinical breast exam (physical exam) by your physician _____
Do you practice self-breast exam? _____

Are you currently having any breast problems:	Yes	No	Which Breast		Duration
Pain/Tenderness	Yes	No	R	L	_____
Lump/Thickening	Yes	No	R	L	_____
Nipple Discharge/Bleeding	Yes	No	R	L	_____
Other Problems	Yes	No	R	L	_____

Please indicate if you are currently taking any hormonal medication ❑ Yes ❑ No
Name of medication _____ Duration _____

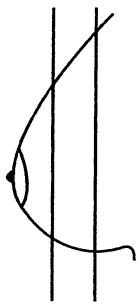
Have any of your close blood relatives been diagnosed with breast cancer?
Relationship _____ Age at diagnosis _____

Have you ever been diagnosed with breast cancer? ❑ Yes ❑ No
If yes, what treatments did you receive?

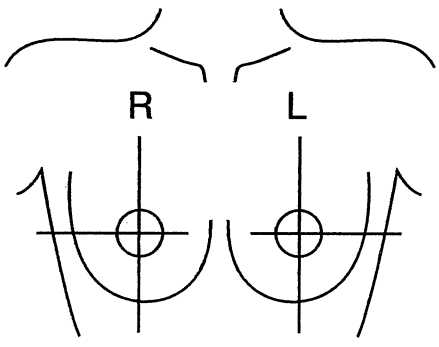
Mastectomy	Right	Left	Date _____
Lumpectomy	Right	Left	Date _____
Radiation Therapy	Right	Left	Date _____
Chemotherapy	Right	Left	Date _____
Reconstruction	Right	Left	Date _____

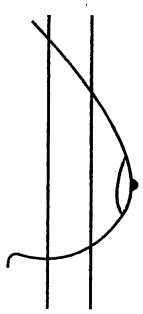
Have you ever had any breast procedures:

Surgical Biopsy	Right	Left	Date _____
Ultrasound Core Biopsy	Right	Left	Date _____
Cyst Aspiration	Right	Left	Date _____
Mammotome	Right	Left	Date _____
Implants	Right	Left	Date _____
Reduction	Right	Left	Date _____



Right





Left

FORTUNATO BREAST HEALTH CENTER – MALE BREAST EXAM