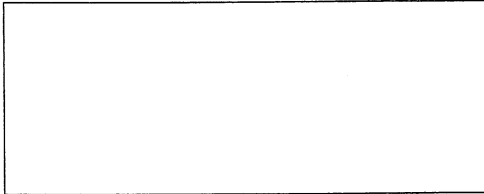
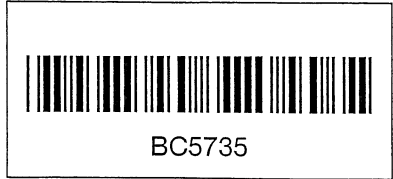


Date _____

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



Patient Label



Name _____ Home Phone _____

Address _____ Cell Phone _____

Date of Birth _____ Do you practice self-breast exam? Yes No

Date of last clinical breast exam (physical exam) by your physician _____

Is this your first mammo _____ Date & Location of your last mammo _____

Is there a possibility you could be pregnant? Yes No Date of last menstrual period _____

Age when period started _____ Age when period ended _____

Your age when your first child was born _____ Number of completed pregnancies _____

To facilitate individual breast cancer risk assessment, please indicate your race/ethnicity:

- White African-American Hispanic Asian-American American Indian Unknown

Are you currently having any breast problems:

Table with columns: Problem (Pain/Tenderness, Lump/Thickening, Nipple Discharge/Bleeding, Other Problems), Yes/No, Which Breast (R/L), and Duration.

Are you currently taking any of the following:

Table with columns: Medication (Hormone Replacement Therapy, Tamoxifen/Arimidex/Femara, etc., Birth Control Pills), Name of Medication, and Duration.

Have any of your close blood relatives been diagnosed with breast cancer?

Relationship _____ Age at diagnosis _____

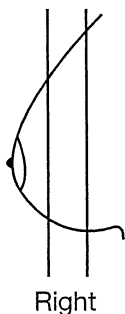
Have you ever been diagnosed with breast cancer? Yes No

If yes, what treatments did you receive?

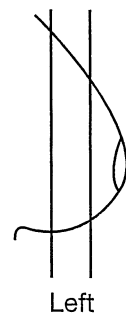
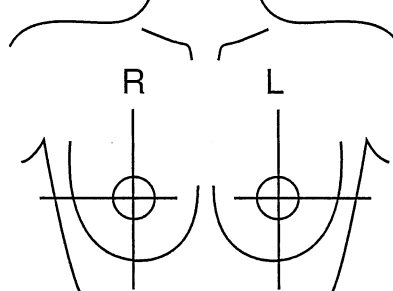
Table listing treatments (Mastectomy, Lumpectomy, Radiation Therapy, Chemotherapy, Reconstruction) with columns for Right/Left breast and Date.

Have you ever had any breast procedures:

Table listing procedures (Surgical Biopsy, Ultrasound Core Biopsy, Cyst Aspiration, Stereotactic Core Biopsy, MRI Guided Biopsy, Implants, Reduction) with columns for Right/Left breast and Date.



Right



Left