

Bright Light Radiology

31 Arlington Heights RD
 Elk Grove Village, IL 60007

Name: _____

DOB: _____ Age: _____

Referred By: _____

Exam Date: _____ Screening/Diagnostic Side _____ Last Menstrual Period: _____
 Date Location

Previous Mammogram _____

Reason for Exam

- First Mammogram
- Screening
- Review of outside study
- Clinical finding
- Pre-reduction Mammoplasty
- Pre-radiation therapy
- Additional evaluation requested from prior outside study
- Follow up at short interval from prior study
- History of breast augmentation; asymptomatic
- Additional evaluation requested at current screening
- History of benign breast biopsy

Indicated Problems

- | | | |
|--------------------------|--------------------------|-------------------------------|
| L | R | |
| <input type="checkbox"/> | <input type="checkbox"/> | Palpable Abnormality |
| <input type="checkbox"/> | <input type="checkbox"/> | Non-bloody discharge |
| <input type="checkbox"/> | <input type="checkbox"/> | Breast Implant Problem |
| <input type="checkbox"/> | <input type="checkbox"/> | Lump or thickening |
| <input type="checkbox"/> | <input type="checkbox"/> | Large Axillary Lymph Nodes |
| <input type="checkbox"/> | <input type="checkbox"/> | Bloody discharge |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficult physical exam |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin thickening or retraction |
| <input type="checkbox"/> | <input type="checkbox"/> | Nipple abnormality |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |

Personal Risk Factors

- Breast Cancer Gene Age _____
- History of Breast Cancer _____
- History of Endometrial Cancer _____
- History of Ovarian Cancer _____
- History of High-Risk Lesion _____
- History of Colon Cancer _____

Family Breast Cancer

Relative	Age
_____	_____
_____	_____
_____	_____

Gynecological History

Age _____

Number of Live Births _____

1st Menstrual Period _____

Menopause _____

Hysterectomy _____

Left Ovary Removed _____

Right Ovary Removed _____

Hormone History

	Currently Using	Duration of Use
Estrogen	<input type="checkbox"/>	____yrs ____mos
Progesterone	<input type="checkbox"/>	____yrs ____mos
Tamoxifen	<input type="checkbox"/>	____yrs ____mos
Unspecified Hormone	<input type="checkbox"/>	____yrs ____mos

Breast Surgical & Treatment History

Breast Implants

- Right Date _____
- Left Date _____

To Be Completed by the Technologist

Any limitations on positioning? Yes No

Staff Comments: _____

Technologist Signature _____

Physical Findings

