WINDSONG
BREAST CARE

(716) 631-2500

# BREAST SCREENING

Do you have a latex sensitivity or allergy? ❑ YES ❑ NO

NAME: _____ DATE OF BIRTH: _____
Please Print

Have you had a previous mammogram? ❑ NO
❑ YES Date: _____ Name of Facility: _____

Are you currently taking hormones? (ex.: HRT, Birth Control)
❑ YES: For how long _____ ❑ NO

Have you had any breast surgery? ❑ NO
❑ YES When: _____ Which Breast: _____ ❑ Implants ❑ Reduction
❑ Surgical Biopsy ❑ Core Biopsy ❑ Lumpectomy for Cancer ❑ Mastectomy

Please circle the type of mammogram you are here for today:
ROUTINE / FOLLOW-UP / PROBLEM: Explain _____

Do you have any family history of breast cancer? ❑ NO
❑ YES Who: ❑ Mother ❑ Sister ❑ Daughter ❑ Father ❑ Brother ❑ Other_____
Age of Diagnosis_____

Do you have any family history of ovarian cancer? ❑ YES ❑ NO

Have you ever had genetic testing? ❑ YES ❑ NO

Do **YOU** have any personal history of cancer? ❑ NO
❑ Ovarian Cancer ❑ Breast Cancer ❑ Other: _____

Have you had chest or mantle radiation therapy before age 30? ❑ YES ❑ NO

Was your first child born after age 30? ❑ YES ❑ NO ❑ NO Children

| | | | | |
|---|---|---|---|---|
| ❑ NO Changes | ❑ NO Changes | ❑ NO Changes | ❑ NO Changes | ❑ NO Changes |
| ❑ Changes above | ❑ Changes above | ❑ Changes above | ❑ Changes above | ❑ Changes above |
| ❑ Have you had a breast exam in the last year? | ❑ Have you had a breast exam in the last year? | ❑ Have you had a breast exam in the last year? | ❑ Have you had a breast exam in the last year? | ❑ Have you had a breast exam in the last year? |
| Signature | Signature | Signature | Signature | Signature |
| Date:_____ | Date:_____ | Date:_____ | Date:_____ | Date:_____ |