INNOVACARE LLC
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WOMEN'S DIAGNOSTIC CENTER

You may now type in your information into document before printing.

MEDICAL HISTORY FOR BREAST DIAGNOSTIC EXAMINATION

Name _____ Date_____

Date of Birth_____ Phone Number_____

Your Doctor's Full Name where we will send your results:

_____

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:_____

_____