Breast HealthCare Center
Missouri Baptist Medical Center
BJC HealthCare

Patient Identification Label

PATIENT INFORMATION SHEET

TODAY'S DATE:	AGE:	DATE OF BIRTH:	☐ SCREENING
MRN#:			☐ DIAGNOSTIC

FIRST NAME: **LAST NAME:**

DOCTOR(S) TO RECEIVE RESULTS:

HEIGHT (feet/inches):	WEIGHT (pounds):

Are you now, or could you be pregnant? ☐ No ☐ Yes
Are you currently nursing? ☐ No ☐ Yes
When was your last mammogram *(month/year):* _____ ☐ Not sure *Where?* _____
Are you experiencing any breast problems today? ☐ No *(skip to next question)*
☐ Yes - *IF YES, describe:* _____
Do you have breast implants? ☐ No ☐ Yes *IF YES, type:* _____
How old were you when you started your periods? *(Age: _____)*
Have you given birth? ☐ No ☐ Yes **If yes, how old were you when your first child was born?** *(Age: _____)*
Have you gone through menopause? *(Defined as no periods for 1 year without surgery)* ☐ No ☐ Yes *(Age: _____)*
Have you had a hysterectomy? ☐ No ☐ Yes *(Age: _____)* **If yes, were your ovaries also removed?** ☐ No ☐ Yes

Have you ever used hormone replacement therapy (HRT)? ☐ No ☐ Yes ☐ Not sure

Circle type: **ESTROGEN ONLY** / **PROGESTERONE ONLY** / **ESTROGEN & PROGESTERONE**

If yes, currently using? ☐ No ☐ Yes How Long: _____
Formerly used? ☐ No ☐ Yes How Long: _____
When did therapy stop? _____

Do you have a personal history of any type of cancer? ☐ No ☐ Yes If yes, please describe: _____
If you have been diagnosed with breast cancer, at what age were you diagnosed? _____

Check all that apply:

☐ Lumpectomy ☐ Right ☐ Left Date: _____ ☐ Chemotherapy Date Completed: _____
☐ Mastectomy ☐ Right ☐ Left Date: _____ ☐ Radiation Therapy Date Completed: _____
☐ Currently taking anti-estrogen therapy (Tamoxifen, Raloxifene, Aromasin, etc.)

Have you ever had a breast biopsy? ☐ No *(skip to next section)* ☐ Yes *(detail below)*

Check all that apply:

☐ Fine Needle Aspiration ☐ Right ☐ Left When: _____
☐ Core Needle Biopsy ☐ Right ☐ Left When: _____
☐ Surgical ☐ Right ☐ Left When: _____
☐ Not sure of type ☐ Right ☐ Left When: _____

Have you had any type of breast surgery for any reason other than breast cancer? ☐ No *(skip to next question)*
☐ Yes *IF YES, describe:* _____ ☐ Right Breast ☐ Left Breast When: _____

Do you have a history of prior radiation therapy to your chest for any reason other than breast cancer?
☐ No *(skip to next question)* ☐ Yes, *Why/When:* _____

Do you have a family history of breast or ovarian cancer? ☐ No *(IF NO, your questionnaire is complete)*
☐ Yes *(IF YES, please turn sheet over to provide further details*

Your mammogram results will be mailed to you; however, may we leave a message with a person or voice mail if you need to return for additional imaging? ☐ No ☐ Yes *(Preferred phone number: _____)*

Patient Signature: _____ Date: _____ Time: _____

DO NOT WRITE BELOW THIS LINE

MBMCBHC15-3343-002

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PATIENT INFORMATION SHEET

Please mark the boxes below regarding your family history.

Breast Cancer / Age(s) at Diagnosis

	Mother's Side	Father's Side
☐ Sister(s) _____	☐ Mother _____	☐ Father _____
☐ Brother(s) _____	☐ Grandmother _____	☐ Grandmother _____
☐ Daughter(s) _____	☐ Aunt(s) _____	☐ Aunt(s) _____
☐ Son(s) _____	☐ Other: _____	☐ Other: _____

Ovarian Cancer / Age(s) at Diagnosis

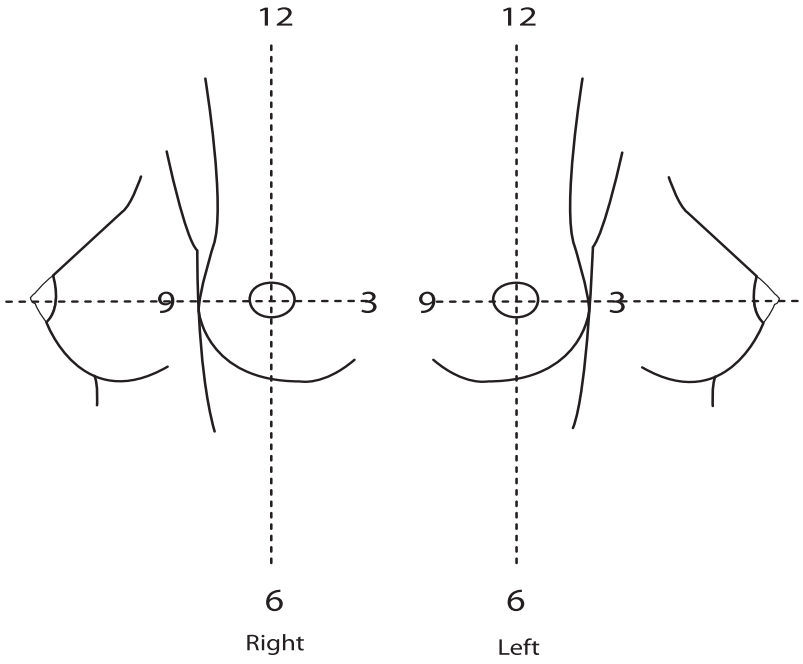
	Mother's Side	Father's Side
☐ Yourself _____	☐ Mother _____	☐ Grandmother _____
☐ Sister(s) _____	☐ Grandmother _____	☐ Aunt(s) _____
☐ Daughter(s) _____	☐ Aunt(s) _____	☐ Other: _____
	☐ Other: _____	

Are you of Ashkenazi Jewish descent? ☐ Yes ☐ Maternal ☐ Paternal ☐ No
☐ Other: _____

Please indicate below if you, or a family member has a history of ANY of the following cancers:

	Self	Family		Self	Family		Self	Family
Sarcoma	☐	☐	Pancreatic	☐	☐	Melanoma	☐	☐
Thyroid	☐	☐	Kidney (Renal)	☐	☐	Colon/Rectal	☐	☐

TECHNOLOGIST SECTION BELOW



Technologist Signature: _____ Date: _____ Time: _____

DO NOT WRITE BELOW THIS LINE

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