Screening

The Katherine M. Cyran M.D. Breast Center

Last name: ________________________ First: ________________________ MI: ________

DOB: ______________ Age: ________ **Nursing Currently/ Recently (within past 6 months)**? Y N

Previous last name?: ________________ Report to other Doctor?: Y N (who?) ______________

Email: ______________________________________ May we send results via email? Y N

Medical History:

Last Menstrual Cycle: ______________ **Are you pregnant**? Y N **Do you have Breast Implants** ? Y N

Age First Menstruation: _______ **# C**hildren Birthed: _______ **Age 1st** full-term pregnancy: __________

Age **M**enopause or N/A: ______ Age **H**ysterectomy or N/A: _____ **O**varies removed? Y N **H**eight: ______ **W**eight: ______

Hormone Replacement? Y N **C**urrently? Y N **P**reviously? Y N **T**ype: Estrogen Only___ Combined ___ **D**uration: ______

Family History of Breast/Ovarian Cancer:

______ Unknown

_______ No family history

_______ Aunt, Grandmother, Cousin (weak)

_______ **Post**-menopausal Mother, Sister (intermediate)

_______ **Pre**-menopausal Mother, Sister **OR** multiple first degree relatives (high)

Personal History of Cancer:

_____ Breast

_____ Ovarian

Breast History:

Last mammogram (year):__________**L**ocation:______________________________

Ultrasound (year):__________ **L**ocation: ______________________________

Biopsy (year): __________ R L Both **R**esults: ______________________________

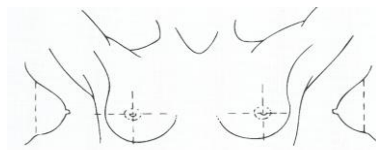
Lumpectomy (year): ________ R L Both **R**adiation (year): _________ **M**astectomy (year) __________ R L Both

Implants (year): ________ Reduction (year): ________ Other Breast Surgery (describe): ______________

____

Patient Signature: ______________________________ Date: ______________

Tech Notes:



Tech Signature: ______________________________ Date: ______________

Physician Notes: