WOMAN'S CLINIC
for Breast & Gynecological Care

2424 W Holcombe Blvd Suite 102**Todays Date:**
Houston, TX 77030

Name: DOB: AGE: Referring Physician:

Pregnant Y / N BreastfeedingY / N Age at first Period _____ Last Period: _____

Number of pregnancy's___	(Menopause age)___	(Birth control Y/ N)	(Hormone use) Y/ N
(Births)___	(Hysterectomy) Y/ N	How many years __	How many years___
Age at first full term birth _____	(Ovaries Removed) Y/ N		Rx Name:_____
	(Self-Breast Exams) Y/N		

PERSONAL HISTORY OF ANY TYPE OF CANCER:
_____

FAMILY HISTORY OF BREAST CANCER & AGE AT DIAGNOSIS:
_____

FAMILY HISTORY OF OVARIAN CANCER & AGE AT DIAGNOSIS:
_____

BREAST SURGICAL HISTORY (CIRCLE ALL THAT APPLY):
BREAST IMPLANTS: RIGHT LEFT BILATERAL SILICONE/SALINE YEAR PLACED? _____
REDUCTION: RIGHT LEFT BILATERAL YEAR? _____
BIOPSY: RIGHT LEFT BILATERAL YEAR? _____

BREAST CANCER PATIENTS:
LUMPECTOMY: RIGHT LEFT BILATERAL YEAR DIAGNOSED? _____
MASTECTOMY: RIGHT LEFT BILATERAL YEAR DIAGNOSED? _____
RADIATION THERAPY: Y N YEAR? _____ **CHEMOTHERAPY?** _____

Date of Last Mammogram: _ _ /_ _ /_ _ _ _ Location of Facility:_____

Patient Signature:_____Phone#_____
****Office Use ONLY** _ _ _ _ _**

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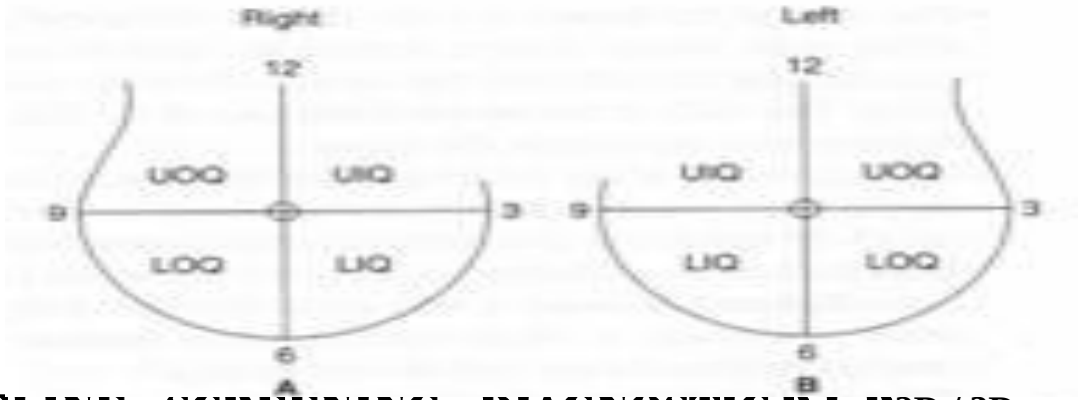

BASELINE SCREENING DIAGNOSTIC R L B2D / 3D

BC# ***TECHNOLIGIST: Mary***