



BRC # _____

Technologist _____

Name _____ Age _____ Date _____

Date of Birth _____ Phone (____) _____

Address _____

City _____ State _____ Zip Code _____

(Please place a check in the appropriate column to the right)	Yes	No	Right Breast	Left Breast
Lump in breast	_____	_____	_____	_____
Soreness or tenderness of the breast	_____	_____	_____	_____
Nipple Discharge Milky _____ Clear _____ Bloody _____	_____	_____	_____	_____
Have you had a previous breast surgery or biopsy?	_____	_____	_____	_____
Are you on hormones?	_____	_____	_____	_____
Do you have a family history of Breast cancer?	_____	_____	_____	_____
If yes, please list relative(s):	_____			

Have you had a previous mammogram?	_____	_____	_____	_____
If yes, where and when?	_____			

Do you have breast implants?	_____	_____	_____	_____

(For staff use only. Please do not mark on illustration.)

* = Lump x = Mole / = Scar ø = Inverted Nipples

Right Breast

Left Breast

