WOMEN'S DIGITAL IMAGING

LISA R. WEINSTOCK, MD

Women's Digital Imaging of Ridgewood
79 Chestnut Street | Ridgewood | NJ 07450-3235

TEL 201.444.4484 | FAX 201.444.4148 | www.womensdigital.com

Patient History Form

Patient Name: _____ DOB: _____ Age: _____

Reason for Visit *(Please Circle one)*: Routine Mammogram Ultrasound Both

Personal History		**Personal History**	
Date of last clinical Breast Exam by your doctor **not here**		Age at first Child Number of Children	
Height Weight		Ashkenazi Descent? Yes/No?	
Recent weight loss or gain		BRCA Gene? Pos/Neg? Who?	
Age at first Menstruation		Any history of chest radiation?	
Date of last Menstrual Period		Date of Prior BSGI (Molecular Imaging)	
Have you had hysterectomy or ovaries removed?		Date of Prior **Breast** MRI	
Age at Menopause		**New Patients Only:** Date of Prior Outside Mammogram	
Are you Pregnant?			
Number of Pregnancies			

Please try to answer these questions to the best of your ability. This information will be used to perform a risk assessment. Thank you.

Recent Breast Problems	**Yes/No**	**Right/Left**
New Lump/Thickening		
Pain		
Nipple Discharge		
Swelling		
Nipple Retraction		
Skin Thickening		
Skin Change		
Prior Biopsy showing high risk lesion such as atypia, radial scar, LCIS, ALH		

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Medication Use	Yes/No	Age/How long
Contraceptives		
IVF / Fertility		
Estrogen including cream		
Progesterone		
Synthroid		
Tamoxifen		
Aromasin		
Evista		
Arimadex		
Femara		
Other:		

Breast Procedure History	Yes/No	Right/Left	Dates/Year
Aspiration (FNA or Cyst)			
Biopsy (U/S or Stereotactic)			
Excisional (lumpectomy) benign or atypia			
Lumpectomy for cancer			
Radiation Therapy			
Chemotherapy			
Mastectomy			
Reconstruction			
Reduction			
Implants			

I authorize Women's Digital imaging to obtain pathology results from my doctor/ hospital/ surgeon in accordance with the FDA

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under MQSA regulations and guidelines. I verify that answers I have provided to questions on this form are correct and understand that withholding information or inaccurate information may adversely affect the interpretation of this exam.

Patient Signature: _____ Date: _____

Best way to contact you to confirm future appointments: _____

(Email / Home & Cell Phone)

Tech Signature: _____

Ambry Genetics

Hereditary Cancer Questionnaire
(to be completed by patients)

Patient Name: _____

Date of Birth: _____

Today's Date: _____

Instructions: This is a screening tool to help your healthcare provider determine if you would benefit from hereditary cancer genetic testing. Your healthcare provider will review this form looking for any risk factors for a hereditary cancer syndrome such as similar types of cancer running in the family, cancers diagnosed at young ages, or multiple cancer diagnoses in the same person.

DOES CANCER RUN IN YOUR FAMILY? CHECK THOSE THAT APPLY.

Please fill this form out to the best of your ability. Please only consider family members related to you **by blood**, such as your parents, grandparents, children, brothers, sisters, aunts, uncles, and cousins. If you share only one parent with a brother or sister, **please indicate that.**

	TYPE OF CANCER	YOURSELF/PARENTS/ BROTHERS/ SISTERS/CHILDREN	AGE AT DIAGNOSIS (estimates are OK)	EXTENDED FAMILY (MOTHER'S SIDE) Aunts/Uncles/Cousins/ Grandparents /Other	AGE AT DIAGNOSIS (estimates are OK)	EXTENDED FAMILY (FATHER'S SIDE) Aunts/Uncles/Cousins/ Grandparents /Other	AGE AT DIAGNOSIS (estimates are OK)
☑	EXAMPLE: Colorectal Cancer	Me	42			Aunt Uncle	46 55
☐	BREAST CANCER (in women or men)						
☐	OVARIAN CANCER (peritoneal/ fallopian tube)						
☐	UTERINE (ENDOMETRIAL) CANCER						
☐	COLORECTAL CANCER						
☐	PANCREATIC CANCER						
☐	KIDNEY (RENAL) CANCER						
☐	OTHER CANCER Type: _____						
☐	OTHER CANCER Type: _____						
☐	OTHER CANCER Type: _____						
☐	MORE THAN 10 COLORECTAL POLYPS (indicate how many)						

☐ My family's heritage is Ashkenazi Jewish (an ethnic background that may have a higher likelihood of hereditary cancer)

☐ I, or someone in my family, have had genetic testing for a hereditary cancer syndrome.
(Please describe and provide a copy of result if possible)

_____

_____