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: _____