MALE BREAST HISTORY FORM

NAME:_____ TECH INITIAL:_____

SS#:_____ DOB:_____

OCCUPATION:_____

CURRENT BREAST HISTORY: (answer YES or NO)

1. Do you have a lump? _____ Circle: Right / Left / Both
   Length of time you have noticed the lump? _____
2. Do you have pain or tenderness? _____ Circle: Right / Left / Both
   Length of time you have noticed the pain? _____
3. Do you have any other breast complaints? _____
4. Have you ever had a mammogram before? _____ If yes, when? _____
5. Do you have any family history of breast cancer? _____
   List: _____
   _____
6. Have you had ANY TYPE of Cancer yourself? _____
   List type and whether you had Radiation or Chemotherapy? _____
   _____

LIST MEDICATIONS YOU ARE CURRENTLY TAKING:

1._____ 2._____

3._____ 4._____

LIST PREVIOUS SURGICAL PROCEDURES:

1._____ 2._____

3._____ 4._____

SOCIAL HISTORY:

Do you Smoke?_____ # a day _____

Alcohol Use: Yes or No (circle) Infrequently --- 1 or 2 drinks a day --- 3 or more

COMMENTS:

_____

_____

_____

SIGNATURE I ATTEST THAT THE INFORMATION I HAVE PROVIDED ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE. _____ _____ SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO CONSENT FOR PATIENT DATE	INFECTION CONTROL? Y/N _____ _____ TECHNOLOGIST