BREAST CENTER of ACADIANA

FOR OFFICE USE ONLY

Patient Name: _____ **DOB:** _____

Is the patient currently pregnant? ☐ **YES** ☐ **NO** **Tech Initials:** _____

BREAST SURGICAL HISTORY

INDICATE DATE (MONTH/YEAR) OF EACH INCIDENT AND WHETHER BENIGN (B) OR MALIGNANT (M) IF APPLICABLE

	R	L	B	B/M		R	L	B
Cyst Aspiration					**Mastectomy** ☐**Nipple Sparing**			
Needle Biopsy					**Radiation/end of treatment**			
Lumpectomy OR Excisional Biopsy					☐**Reduction/Lift** ☐ **Implants** (circle) Saline Silicone ☐ **Reconstruction**			

O **= lump/thickening** **•** **= mole** **≈ = pain** **= scar** *** = other**

Other History:

_____
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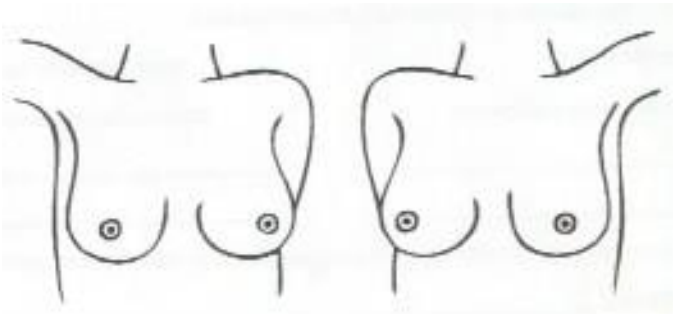

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Tech Assistant Initials: _____ **Date:** _____ **Tech Initials:** _____ **Date:** _____