Screening Site:_____ Date: _____

Patient Name: _____ Age: _____
Address: _____ Phone Number: _____
_____

## Physician Screening Form

### I: Medical History

PMH : _____

_____

Medications: _____

_____

Allergies: _____

Surgeries: _____

**GYN History**: _____ LMP: _____ Last PAP/HPV: _____

GPA: _____ Menarche: _____ Menopause: _____

Birth Control/Hormone Use: _____

**Family History**: _____

**Breast Health History**: _____

_____

### II: Patient Concerns

_____

_____

_____

_____

_____

## III: Breast Examination

*Patient Name*:_____

**Visual Exam:**

Skin: ☐ Normal/Benign ☐ Scar(s) ☐ Dimpling ☐ Other:_____

Nipples: ☐ Everted ☐ Inverted ☐ Retraction ☐ Discharge / Describe _____

**Physical Exam:**

| | Left | Right |
|---|---|---|
| Lymph Nodes (Axillary/Clavicular) | + ☐ - ☐ | + ☐ - ☐ |

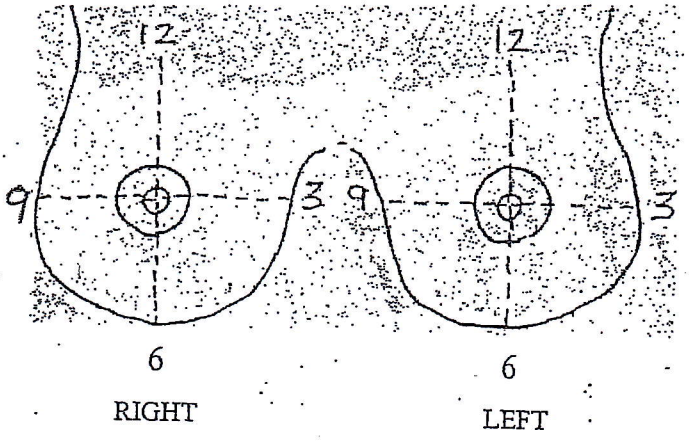


**Diagram Documentation Codes**

| | |
|---|---|
| Scar | Nodularity |
| Mole * | Fibrocystic Area |
| Node o | Dimpling Δ |
| Mass ● | |

Describe size, shape, mobility, clock location and any associated findings: _____

_____

_____

## IV: Plan

[ ] Aspiration of Cyst

[ ] Fine Needle Aspiration

[ ] Mammogram

[ ] Sonogram (Please note findings on diagram)

[ ] Refer to Breast Clinic or other facility: _____

[ ] Biopsy / Spot Localization

[ ] Other: _____

_____

_____
Signature