「(英語版) 乳がん検診記録票」

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Form No. 4 (1) (For Medical Institution)

Utsunomiya City Breast Cancer Screening Record Form

・Please fill out the form neatly in block letters or circle the applicable content.

・This is a carbon copy form, so please write firmly.

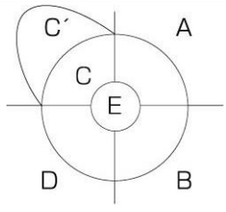
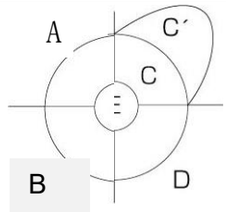
Cost category	1	General	2	Exemptions	Checkup date	Year	Month	Day
Appointment ticket no.						2		

Address	Name
Utsunomiya City Phone no. (_____) _____ - _____	1. Male 2. Female Furigana: _____ Name: _____ Date of birth: _____ (year) ___ (month) ___ (day) Age: ___ years old

Screening history (Please fill in as much as you can.)	(1) First time for breast screening (2) Breast screening in the past My last screening was about ___ years ago (Clinical examination / Mammogram / Breast ultrasound) Screening results: (No abnormalities / Further testing required → Results of that test: _____)
Family history of breast cancer	Has anyone in your family, such as your biological mother or sisters, ever had breast cancer? (1) No (2) Yes (grandmother / mother / sister / daughter / aunt / niece)
Menstrual history	・First menstrual period: ___ years old ・Menstrual Cycle (1) No: Menopause started: ___ years old (2) Yes: Normal / Abnormal Last menstrual period: _____ (month) ___ (day) to _____ (month) ___ (day)
Pregnancy history	(1) No (2) Yes (Number of deliveries) (Normal: ___ times / Abnormal: ___ times) ・Are you currently pregnant? Or is there a possibility that you are pregnant? (1) Not pregnant / no possibility of pregnancy (2) Possibility of pregnancy or currently pregnant
Breastfeeding history	(1) No (2) Yes (3) Currently breastfeeding
Medical history Other	Breast disease (1) No (2) Yes: _____ years old Name of disease: _____ (Right / Left) Surgical treatment (No / Yes) Other disease(s) (1) No (2) Yes: _____ years old Name of disease: _____ ・Do you have a pacemaker? No / Yes ・Have you had breast augmentation surgery? No / Yes ・Have you had breast reconstruction following breast cancer surgery? No / Yes
Current condition of the breasts	Do you have any symptoms? (l) No (2) Yes→ Please fill in the table below with details.

Lump	(Right Left Both) From _____ (year) _____ (month)
Discharge from nipple	(Right Left Both) Color (Bloody, white, clear) From _____ (year) _____ (month)
Other	(Right Left Both) What: _____ From _____ (year) _____ (month)

〈Physical Examination〉 Please fill this out only if findings are present.

	Right	Left
Breasts	 Size cm × cm Hardness: Soft / Medium-Hard / Hard / Fluctuating Dimpling: ＋ ・ —	 Size cm× cm Hardness: Soft / Medium-Hard / Hard / Fluctuating Dimpling: ＋・—
Nipples	Erosion Deformation Abnormal discharge (milky / watery / yellow / brown / bloody)	Erosion Deformation Abnormal discharge (milky / watery / yellow / brown / bloody)
Lymph nodes	Axilla / Supraclavicular fossa	Axilla / Supraclavicular fossa
Remarks		

〈Assessment category〉

1	No abnormalities	
2	No further testing required	(Reason)
3	Further testing required	(Referral medical institution name)

Name of medical institution & physician	