

CANCER SERVICES PROGRAM CLINICAL BREAST EXAM FORM

Name: _____ Date: _____
Last First MI MM/DD/YR

D.O.B.: _____ M.R.# _____ Site Code:
MM/DD/YR

Review of Patient History:

Patient noticed changes in breasts since last visit?
 No _____ Yes _____ Describe _____
 Patient has a personal or family history of breast cancer?
 No _____ Yes _____ Describe _____
 Patient noted spontaneous nipple discharge? No _____ Yes _____ Describe _____

Visual Exam:

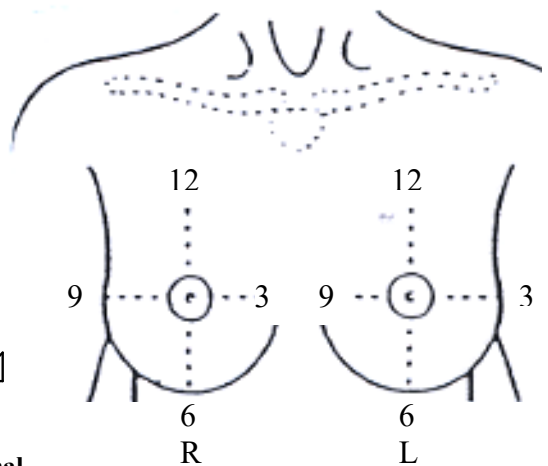
Skin: Normal/Benign Scar(s) Dimpling Other: _____
 Nipples: Everted Inverted Retraction

Physical Exam:

Lymph Nodes + - **Right** + - **Left**
 (Axillary/Clavicular)

Diagram Documentation Codes

Scar +++ Nodularity ≡ Mole *
 Fibrocystic Area ### Node ○ Dimpling ▽
 Mass ●



Describe all clinical exam findings, including normal and abnormal (indicate size, shape, mobility, location of palpable findings).

Findings: _____

Plan: _____

Referral: No _____ Yes _____ (explain) _____

Breast Findings

Check one box only:

- 1. Normal, Benign, Fibrocystic – Rescreen in 1-2 Years
- 2. Probably Benign – Repeat Exam in 3-6 months
- 3. Mass or Other Findings – Immediate Testing

Signature of Examiner _____ Date _____

This report should be maintained as part of the patient medical record.

Fax reports to: 716-858-7992 Questions: 716-858-7376