US BREAST

DATE: ____/___/_____
TECH:_____
ID #: _____

UPDATED 9/29/25 - EA

PATIENT NAME: _____**DOB:**_____/_____/_____**SEX:** M / F

ACUTE HX (location, duration, severity) **:**

_____

_____

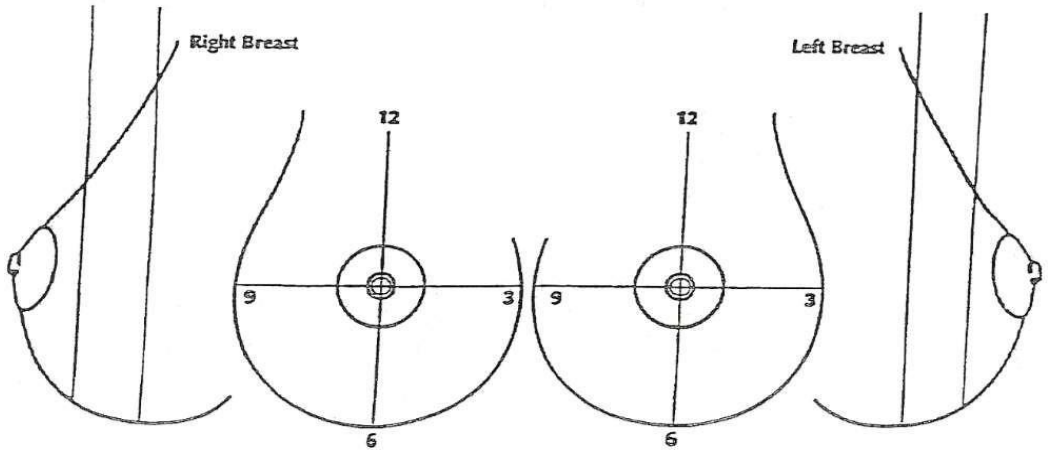
CHRONIC HX: _____

Diabetes HTN COPD CH DV
ETOH Smoking Obesity Renal failure

Surgeries:_____

COMPARISON: YES · NO **DATE:** _____

Diagnostic Workup	Focal Breast Pain	Nipple Discharge	Skin Retraction	Personal Hx of Breast Ca
Palpable Abnormality		Nipple Inversion	Skin Thickening	Family Hx of Breast Ca



RIGHT BREAST/AXILLA

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LEFT BREAST/AXILLA

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Tech Summary: _____
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