

CANCER SERVICES PROGRAM CLINICAL BREAST EXAM FORM

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

Review of Patient History

Patient noticed changes in breasts since last visit? _____

Site code

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No ___ Yes ___ Describe _____

Patient has a personal or family history of breast cancer? _____

No ___ Yes ___ Who? _____ What age? _____

Patient noted spontaneous nipple discharge? _____

No ___ Yes ___ Describe _____

Visual Exam:

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

Nipples: ☐ Everted ☐ Inverted ☐ Retraction

Physical Exam:

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

Diagram Documentation Codes

Scar +++

Fibrocystic Area

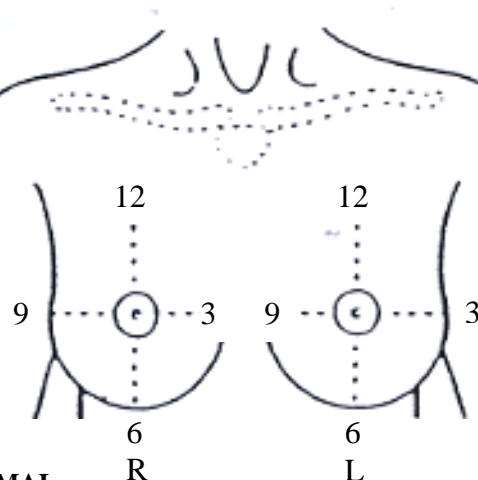
Mass ●

Nodularity ≡

Node ○

Mole *

Dimpling △



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

 Name of Examiner (please print)

 Signature of Examiner

 Date

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

05/22/09