



MAMMOGRAPHY

Name: _____ Age: _____
(Last) (First) (M)

PHYSICAL CONDITION

Yes No Are you pregnant? Date of last menstrual period _____
Yes No Have you breast fed within the last 6 months?
Yes No Are you now taking any type of hormones? If yes, how long _____
Yes No Do you have breast implants? If yes, type _____

REASON FOR EXAM – PLEASE CHECK:

Baseline (No previous mammogram) No Symptoms
Routine Yearly Exam:
Date & Location of prior Mammo, US Breast or MRI Breast _____
Short Term Follow-up _____
Other _____

SYMPTOMS AND HISTORY

Yes No Do you or your doctor feel a lump? Which breast and for how long? _____
Yes No Do you have inverted nipples? Which breast and for how long? _____
Yes No Do you have nipple discharge? Which breast and for how long? _____
Yes No Any other symptoms? Explain _____
Yes No Previous breast surgery? If Yes, which breast and when? _____
Yes No Breast biopsy? Left Right Results were: Benign Malignant
Yes No Radiation treatments to your breast? Which breast and approximate date? _____

RISK FACTORS

Yes No Have you had breast cancer? If yes, which breast and age of diagnosis? _____
Yes No Has any relative ever had breast cancer? Who: _____ Age when diagnosed? _____
Yes No Have you ever had any other type of cancer? If Yes, type _____
Yes No Have you ever been tested for the breast cancer gene? Comment: _____
True False I have never been pregnant.

Occasionally, the results of a Screening Mammogram require patients to return for an additional Diagnostic Mammogram. This is a separate exam that is performed to evaluate an area of concern.

PATIENT SIGNATURE: _____ DATE OF BIRTH: _____

FOR TECHNOLOGIST USE ONLY
↓ DO NOT WRITE BELOW THIS LINE ↓

Date: _____ X-ray Number: _____ Technologist: _____

History/Clinical Symptoms:

