Women's imaging specialists

Mammography History Sheet

Today's Date: _____/_____/_____

Patient Name: _____

Patient's Date of Birth: _____/_____/_____Last Menstrual Cycle_____/_____/_____

Are you currently pregnant or breast feeding? YES NO

Have you ever had a mammogram? YES NO

If YES - Place of last Mammogram: _____Date of Last Mammogram: ____/___/_____

Do you currently have any new breast problems that have occurred since your prior mammogram? YES NO

If YES – Please provide details:_____

YES	NO		Right	Left
_____	_____	Do you have any **NEW** lump(s) in either breast?	_____	_____
_____	_____	Pain or discomfort?	_____	_____
_____	_____	Discharge from nipple: Color _____	_____	_____

Please check if you have had any of the following:

YES	NO		Right	Left
_____	_____	Mastectomy	_____	_____
_____	_____	Lumpectomy (removal of Breast Cancer)	_____	_____
_____	_____	Radiation	_____	_____
_____	_____	Chemotherapy	_____	_____
_____	_____	Benign (**Not Cancerous**) biopsy	_____	_____
_____	_____	Augmentation (**Implants**)	_____	_____
_____	_____	Reduction	_____	_____

Personal history of cancer? YES NO Area of body affected? _____

Age of first menstrual period _____ Was your first pregnancy before age 35? YES NO

Number of full pregnancies _____ Did you breast feed? YES NO

Have you had a hysterectomy? YES NO When was your hysterectomy? _____

Are you taking hormones? YES NO How long have you been taking hormones? _____

Family history of BREAST CANCER? YES NO Age relative was diagnosed? _____

Check/Circle all that apply ____Mother____Sister____Daughter_____Aunt_____Grandmother/Other _____

TECHNOLOGIST SECTION

Please identify location of any: Lumps (X) Previous Surgery (X) Moles (O)