



Patient Name: _____ DOB: _____ Medical Record No. _____

Mammography Patient History

Have you ever had a mammogram? Yes No
 If yes, where? _____ When? _____

If it was done under a different name, what name? _____

When was your **last breast exam** in your doctor's office ___Month ___Year Cannot Recall

Reason for this visit: Routine Lump (left right) Discharge (left right)

Please explain: _____

Personal History of Breast Cancer: Yes No
 Treatment Received: Mastectomy Left Right Date: _____
 Lumpectomy (for cancer) Left Right Date: _____
 Radiation Yes No Dates: _____

Family History of Breast Cancer: Yes No Unknown

If YES, check all that apply: Mother Age at diagnosis _____
 Daughter Age at diagnosis _____
 Sister Age at diagnosis _____
 Grandmother Aunt Cousin (Maternal Paternal)

Your other Breast-Related Surgical History:

- Needle Biopsy Left Right Both Date: _____
- Benign Biopsy Left Right Both Date: _____
- Cyst Aspiration Left Right Both Date: _____
- Breast Implants Left Right Both Date: _____
- Breast Reduction Left Right Both Date: _____

Do you take **hormones**? Yes No If yes, for how long? _____

Medical History:

Is there a chance you could be pregnant? Yes No
 Date of last menstrual period? _____
Age at menopause (complete stop of menstruation)? _____
Have you ever given birth? Yes No
 If yes, how old were you? _____

I understand that sometimes a mammogram may result in bruising and mild discomfort. Not all cancers are found on a mammogram. A yearly physical with a physician is an important part of your breast health.

Signature: _____ Date: _____

Daytime phone number if additional imaging is required: _____