MAMMOGRAPHY HISTORY

Name: Today's Date:
MRN: Phone #:
Age: Date of Birth: Physician:

Please Choose: ☐ 3D Screening Mammo

Have you had a mammogram in the past: ☐ No ☐ Yes Facility: Date:

Are you pregnant? ☐ No ☐ Yes

Are you taking Hormone Replacement Therapy? ☐ No ☐ Yes If yes, for how long?

Any new problems with your breasts? ☐ No ☐ Yes If yes, check all that apply:

Have you had Breast Cancer? ☐ No ☐ Yes

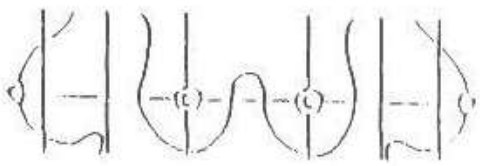
Have you had biopsy or surgery? ☐ No ☐ Yes

If yes, check all that apply:	RT	LT
Pain	☐	☐
Discharge	☐	☐
New Lump	☐	☐

If you answered yes, please check all that apply.

	RT	LT	Dates
Breast Implants	☐	☐	
Cyst Aspiration	☐	☐	
Needle Biopsy	☐	☐	
Surgical Biopsy (not cancer)	☐	☐	
Lumpectomy (for cancer removal)	☐	☐	
Radiation Therapy	☐	☐	
Chemotherapy	☐	☐	
Mastectomy	☐	☐	
Reconstruction	☐	☐	
Breast Reduction	☐	☐	
Other: Explain	☐	☐	

Tech Comments	Tech:



Please mark moles, scars and surgery

Have the following family members had breast cancer? Age at Diagnosis Comments

Mother ☐ No ☐ Yes ☐ I don't know
Sister ☐ No ☐ Yes ☐ I don't know
Daughter ☐ No ☐ Yes ☐ I don't know
Other ☐ No ☐ Yes ☐ I don't know

By signing this, I hereby acknowledge the above to be true, and I authorize the practice to leave my protected Health information (including, but not limited to, results, prescriptions, and appointments) on my voicemail.

Patient Signature:_____ Date:_____