MAMMOGRAPHY HISTORY WORKSHEET

Last Name: _______________ First Name: _______________ Date of Birth: ________Patient Phone Number: _____________

Referring Physician Name: ______________ Referring Physician Phone Number: _______________________

☐Yes ☐No Have you had a mammogram before?
Where? ________________________ When? ____________________

☐Yes ☐No Is this mammogram routine? If no why? ____________________________

☐Yes ☐No Have you had a breast ultrasound before?
Where? ________________________ When? ____________________

☐Yes ☐No Do you have history of breast cancer? I yes ☐RT ☐LT Date: ________________

☐Yes ☐No Do you have a family history of breast cancer?
If yes, in which relative(S)? ☐Mother, age _____ ☐ Grandmother, age _____
☐Aunt, age _____ ☐Sister, age _____ ☐Daughter, age _____ ☐ Cousin, Age _____

☐Yes ☐No Are you still have menstrual periods?
Date of last? _________ Age of first menstruation? ______

☐Yes ☐No Are you pregnant or have you breast fed in the last three months?

☐Yes ☐No Have you had a child? Your age at your child's birth: __________

☐Yes ☐No Have you had a weight change of more than 10 pounds in the past years?

☐Yes ☐No Have you ever had trauma to your breast to cause black and blue marks?

☐Yes ☐No Have you taken any hormone medications? Last date taken? __________
What type? ☐Estrogen ☐Progesterone ☐Birth Control Pills ☐Other ___________

☐Yes ☐No Have you ever been diagnosed or treated for breast cancer?
If yes, which procedure and breast?
☐ Mastectomy ☐ RT ☐ LT Date: ______________________
☐ Lumpectomy ☐ RT ☐ LT Date: ______________________
☐ Radiation ☐ RT ☐ LT Date: ______________________
☐Chemotherapy

☐Yes ☐No Have you had any other of breast surgery?
If yes, what? ☐ Implants ☐ RT ☐ LT Date: ______________________
☐ Reduction ☐ RT ☐ LT Date: ______________________
☐ Biopsy ☐ RT ☐ LT Date: ______________________

I have been informed that it is my responsibility to have all prior mammogram films done at other facilities sent to American Imaging of Southwest FL for proper comparison

Pateint Signature: ____________________________ Date: ____________________

******To be filled out by technologist******

Nipples: ☐ Inverted ☐ Discharge How long? ___________ Moles: _____ Scars:_______ Other _____

☐Yes ☐No Breast Size discrepancy Reason for additional views? ___________________________