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: ________________