

## Mammography Form

Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Are you pregnant or is there any possibility you may be pregnant: No \_\_\_ Yes \_\_\_

Referring Doctor: \_\_\_\_\_ Doctor's Telephone #: \_\_\_\_\_

Doctor's Address: \_\_\_\_\_

Reason for today's visit: Annual / If not annual, \_\_\_\_\_

Have you had a previous Mammogram? No \_\_\_ Yes \_\_\_ When \_\_\_\_\_ Where \_\_\_\_\_

What was the date of your last screening Mammogram? \_\_\_\_\_

Date of last breast examination: \_\_\_\_\_ By whom : \_\_\_\_\_

Date of last period: \_\_\_\_\_ Number of pregnancies: \_\_\_\_\_ Number of children: \_\_\_\_\_

Are you currently taking hormones? No \_\_\_ Yes \_\_\_ Which? \_\_\_\_\_ For how long? \_\_\_\_\_

Are you taking Tamoxifen or Nolvadex? No \_\_\_ Yes \_\_\_

Have you had a breast biopsy/surgery/implant? No \_\_\_ Yes \_\_\_ Which breast: \_\_\_ Date \_\_\_\_\_

Have you ever had radiation therapy to your breast(s)? No \_\_\_ Yes \_\_\_ When: \_\_\_\_\_ Where: \_\_\_\_\_

Have you ever had any type of cancer? No \_\_\_ Yes \_\_\_ Where and Type: \_\_\_\_\_

Is there a family history of ovarian cancer? No \_\_\_ Yes \_\_\_

Has anyone in your family had breast cancer? No \_\_\_ Yes \_\_\_ If yes, Mother \_\_\_

Grandmother \_\_\_ Sister \_\_\_ Maternal Aunt \_\_\_ Other \_\_\_\_\_

Please indicate age at diagnosis: \_\_\_\_\_

Please note any of the following that apply to you and note right or left breast

			Right	Left
Breast Lump	YES	NO	_____	_____
Pain, soreness, discomfort	YES	NO	_____	_____
Nipple discharge	YES	NO	_____	_____
Inverted Nipple	YES	NO	_____	_____
Skin change	YES	NO	_____	_____
Other complaint	YES	NO	_____	_____

Do you practice self examination of the breast? Yes \_\_\_ No \_\_\_

**Signature:** \_\_\_\_\_ (Note: If there is deodorant or powder on your breast, please wash prior to Mammogram. Ask the Technologist for help, if needed.)

