OUTPATIENT DIAGNOSTIC CENTER WOMEN'S WELLNESS

Mammography History Form

PATIENT INFORMATION **Fall Precaution** ☐ YES ☐ NO

Last Name	First Name/Middle Initial	DOB	Age	Race
		/ /		

Is today's evaluation your first mammogram: ☐ YES ☐ NO

If not, year and location of your last mammogram_____

Year of your last breast exam performed by a healthcare professional_____

CURRENT SYMPTOMS

	Which breast?	Duration?
Lump:	**L / R**	_____
Nipple inversion:	**L / R**	_____
Skin retraction:	**L / R**	_____
Tenderness :	**L / R**	_____
Discharge:	**L / R**	_____

Color of discharge: _____

Other symptoms: _____

_____

BREAST CANCER HISTORY

Have you ever had breast cancer? ☐ YES ☐ NO

If yes, please answer the following:

Which breast? ☐ RIGHT ☐ LEFT

Year of diagnosis: _____

Type of surgery: ☐ **Lumpectomy** ☐ **Mastectomy**

Did you have chemotherapy? ☐ YES ☐ NO

Did you have radiation? ☐ YES ☐ NO

Name of surgeon: _____

Name of medical oncologist: _____

Name of radiation oncologist: _____

HORMONE HISTORY

Date of your last menstrual period: _____

Have you ever taken hormones?: ☐ YES ☐ NO

If yes, list type (birth control, hormone replacement, etc) and dates of use: _____

_____

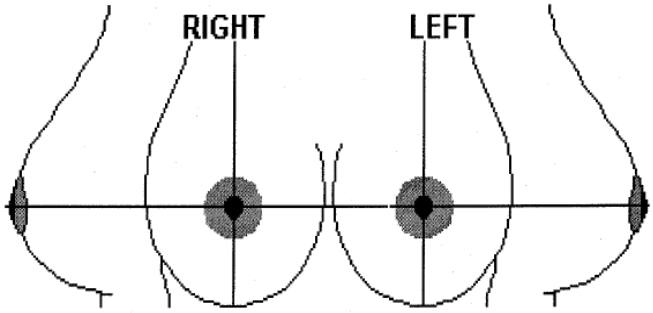
Breast fed in the last six months? ☐ YES ☐ NO

Currently breast feeding? ☐ YES ☐ NO

Weight changed more than 15 lbs since your last mammogram? ☐ YES ☐ NO

If yes, please specify:_____

FOR TECHNOLOGIST USE ONLY



BREAST SURGICAL & BIOPSY HISTORY

Breast reduction: ☐ YES ☐ NO **if yes, year** _____

Implants: ☐ YES ☐ NO **if yes, year** _____

Please list any previous benign breast surgeries or biopsies, including which breast and the approximate year:

_____

_____

_____

TECHNOLOGIST COMMENTS

_____

TECHNOLOGIST SIGNATURE, DATE & TIME