MAMMOGRAPHY SCREENING

Reason for mammography: _____ **Routine** _____ **Six Month Follow up**

_____ Breast Problem (Select and specify left/right both breast (s)
_____ Lump → **Left Right Both**
_____ Nipple Discharge → **Left Right Both**
_____ Pain → **Left Right Both**

If you have a lump, discharge or pain, please describe: _____

Is this your first mammogram? **Yes No**

If not, where and when was your last mammogram?
Location: _____ Date: _____

Have you had any of the follow?

Breast Reduction	**Yes**	**No**				
Implants	**Yes**	**No**				
Benign Biopsy	**Yes**	**No**	**Left**	**Right**	**Both**	**Date:** _____
Malignant Lumpectomy	Yes	No	**Left**	**Right**	**Both**	**Date:** _____
Mastectomy	**Yes**	**No**	**Left**	**Right**	**Both**	**Date:** _____

Have you had any of the following?

Radiation	Yes	No
Chemotherapy	Yes	No
Reconstructive Surgery	Yes	No

Is there any possibility that you might be pregnant? **Yes No**

Number of pregnancies? _____ Your age at first live birth? _____

Date of last menstrual period: (if recent) _____ Hysterectomy **Yes No When?** _____

Are you taking any hormones currently? **Yes No**
If so, list type and duration: _____

Do you have a family history of breast cancer? **Yes No**

_____ Mother Age of onset: _____
_____ Daughter Age of onset: _____
_____ Grandmother Age of onset: _____
_____ Sister Age of onset: _____

Do you have a personal history of breast cancer? **Yes No**

Amount of weight gain or loss (more than 10 lbs) since last mammogram? _____

Is there anything else we should know about your health? _____

_____ _____
Patient Signature **Date**