Hackensack Radiology Group/New Century Imaging
Mammography Screening Sheet

Reason for today's Mammography: Routine ____ Six month follow up ____ Problem____

Lump: Left Right Both Duration:_____
Pain: Left Right Both Duration:_____
Nipple Discharge: Left Right Both Duration:_____
Please explain: _____

Is this your first mammogram? Yes No
Was your last mammogram performed here Yes No Date:_____
If no, location: _____ Date:_____

Previous Procedures:
(If yes, circle **R** for right, **L** for left or **B** for both)

R L B Needle biopsy Date: _____
R L B Surgical biopsy Date:_____
R L B Mastectomy Date: _____
R L B Lumpectomy for cancer Date: _____
R L B Radiation therapy Date: _____
R L B Breast reduction Date: _____
R L B Implants removed Date: _____

Do you have Implants? ___Yes ___No
(If yes, circle **R** for right, **L** for left or **B** for both)

R L B I don't know type
R L B Silicone gel implant
R L B Saline implant
R L B Combination implant

Date of Implants: _____

Menstrual / Pregnancy History:
Date of last period:_____
Hysterectomy : ____No ____Partial ____Total
Your age at time of first live birth? _____

Could you be pregnant? ____ Yes ____ No
Number of pregnancies: _____
Are you breast feeding? ____Yes _____ No

Family History of Breast Cancer:
____ Mother Age of onset:____
____ Sister Age of onset:____
____ Grandmother Age of onset:____
____ Cousin Age of onset:____
____ Aunt Age of onset:____

____ I do not know my family history

Hormone History:
Hormonal contraceptives ____ Yes ____ No
Estrogen ____ Yes ____ No
Progesterone ____ Yes ____ No

Other Risk Factors:
____ I am BRCA positive
____ I have had radiation to my chest (i.e. Lymphoma)

I have experienced weight change (10 Pounds) since my last mammogram ____ No ____gain ____lost

Patient Signature: _____ Date: _____

**********For office use only**********

RIGHT LEFT