



MAMMOGRAPH

Name: _____ Age: _____
(Last) (First) (M)

Did you receive our phone message reminder for your yearly mammogram? Yes No
Was this helpful to encourage you to make your mammogram appointment? Yes No

Comment: _____

PHYSICAL CONDITION

- Yes No Are you pregnant? Date of last menstrual period _____
- Yes No Have you breast fed within the last 6 months?
- Yes No Are you now taking any type of hormones? If yes, how long _____
- Yes No Do you have breast implants? If yes, type _____

REASON FOR EXAM - PLEASE CHECK:

- _____ Baseline (No previous mammogram) No Symptoms
- _____ Routine Yearly Exam - Date and Location of prior exam _____
- _____ Short Term Follow-up _____
- _____ Other _____

SYMPTOMS AND HISTORY

- Yes No Do you or your doctor feel a lump? Which breast and for how long? _____
- Yes No Do you have inverted nipples? Which breast and for how long? _____
- Yes No Do you have nipple discharge? Which breast and for how long? _____
- Yes No Any other symptoms? Explain _____
- Yes No Previous breast surgery? If Yes, which breast and when? _____
- Yes No Breast biopsy? _____ Left _____ Right Results were: _____ Benign _____ Malignant
- Yes No Radiation treatments to your breast? Which breast and approximate date? _____

RISK FACTORS

- Yes No Have you had breast cancer? If yes, which breast and age of diagnosis? _____
- Yes No Has any relative ever had breast cancer? Who: _____ Age when diagnosed? _____
- Yes No Have you ever had any other type of cancer? If Yes, type _____
- Yes No Have you ever been tested for the breast cancer gene? Comment: _____
- True False I have never been pregnant.

Occasionally, the results of a Screening Mammogram require patients to return for an additional Diagnostic Mammogram. This is a separate exam that is performed to evaluate an area of concern.

PATIENT SIGNATURE: _____ DATE OF BIRTH: _____

FOR TECHNOLOGIST USE ONLY
↓ DO NOT WRITE BELOW THIS LINE ↓

Date: _____ X-ray Number: _____ Technologist: _____

History/Clinical Symptoms:



