

# MAMMOGRAPHY

Name: \_\_\_\_\_ Age: \_\_\_\_\_

**REASON FOR EXAM – PLEASE CHECK:**

- Baseline (No previous mammogram) No Symptoms     Routine Yearly Exam     Short Term Follow-up \_\_\_\_\_  
 Other: \_\_\_\_\_ Last Mammo at: \_\_\_\_\_ Previous MRI Breast or US Breast? \_\_\_\_\_

**SYMPTOMS AND HISTORY**

- 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 \_\_\_\_\_  
 Yes     No    Do you or your doctor feel a lump? Which breast and for how long? \_\_\_\_\_  
 Yes     No    Do you have inverted nipples or a 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? R# \_\_\_\_\_ L# \_\_\_\_\_ Results were:     Benign     Malignant     Atypia  
 Yes     No    Have you had breast cancer? If yes,  R     L    What Type? \_\_\_\_\_  
 Yes     No    Radiation treatments to your breast?  R     L    What Year? \_\_\_\_\_  
 Yes     No    Chemotherapy?    Approx Date: \_\_\_\_\_    Hormonal therapy?    Approx Date: \_\_\_\_\_  
 Yes     No    Have you ever had any other type of cancer? If Yes, type \_\_\_\_\_

**RISK FACTORS – Used to calculate a personalized Breast Cancer Risk Assessment (Claus model)**

List relatives who have a history of breast or ovarian cancer & their age of onset below:

1st degree relatives	2nd degree relatives Mother's Side	2nd degree relatives Father's Side
<i>Parents, Siblings, Children</i>	<i>Grandparents, Aunts, Nieces, Half-siblings</i>	<i>Grandparents, Aunts, Nieces, Half-siblings</i>
_____ Age of Onset: _____ <input type="checkbox"/> Breast <input type="checkbox"/> Ovarian ( Relative)	_____ Age of Onset: _____ <input type="checkbox"/> Breast <input type="checkbox"/> Ovarian ( Relative)	_____ Age of Onset: _____ <input type="checkbox"/> Breast <input type="checkbox"/> Ovarian ( Relative)
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- ▶ Do you have or does a first degree relative have the BRCA1 or BRCA 2 gene mutation?     Yes     No  
 ▶ Do you have a history of radiation therapy to the chest between ages 10 and 30 years?     Yes     No  
 ▶ Do you have or does your first degree relative have a history of Li-Fraumeni syndrome, Cowden syndrome or Bannayan-Riley Ruvalcaba syndrome?     Yes     No (If yes, please circle which syndrome)

PATIENT SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

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

Date: \_\_\_\_\_ X-ray #: \_\_\_\_\_ Tech: \_\_\_\_\_      CLAUS SCORE:  Less than 20%  
 History/Clinical Symptoms: \_\_\_\_\_       Greater than 20%

