

Date \_\_\_\_\_ Patient Name \_\_\_\_\_ Acct# \_\_\_\_\_

Referring Physician \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_

\*Comparing your current mammogram with any prior mammogram films is a vital necessity for a complete and accurate reading of your films. Please answer the following questions thoroughly:

Have you had a mammogram before? Y N
Where? \_\_\_\_\_ When? \_\_\_\_\_
Did you bring your prior films with you today? Y N
If no, where are they now? \_\_\_\_\_
You will bring them in when? \_\_\_\_\_

Date or age of your last period \_\_\_\_\_
Have you had a hysterectomy? Y N
Are you taking hormones/birth control now? Y N For how long? \_\_\_\_\_
Have you or a family member ever been diagnosed with breast cancer? Y N
Whom? \_\_\_\_\_

Do you have breast implants? Y N What year? \_\_\_\_\_

Have you ever had any breast surgery or biopsy? Y N
Left breast - When? \_\_\_\_\_ Results: \_\_\_\_\_
Right breast - When? \_\_\_\_\_ Results: \_\_\_\_\_

Have you had cancer of any kind? Y N Type(s) \_\_\_\_\_

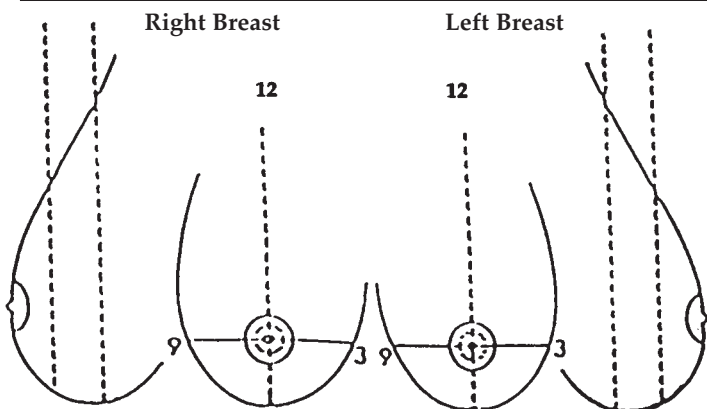
Have you had radiation therapy for breast cancer? Y N

At this time, do you have:

- A new lump? Y N [ ] Right [ ] Left [ ] Both Started when? \_\_\_\_\_
Nipple discharge? Y N [ ] Right [ ] Left [ ] Both Started when? \_\_\_\_\_
Nipple inversion? Y N [ ] Right [ ] Left [ ] Both Started when? \_\_\_\_\_
Breast pain? Y N [ ] Right [ ] Left [ ] Both Started when? \_\_\_\_\_
Moles or scars? Y N [ ] Right [ ] Left [ ] Both Started when? \_\_\_\_\_
Any breast problems? Y N [ ] Right [ ] Left [ ] Both Started when? \_\_\_\_\_

Patient Signature \_\_\_\_\_

please do not write below this line - thank you



\_\_\_ Routine \_\_\_ Add View \_\_\_ Diagnostic

TECH NOTES: \_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

Table with 3 columns: Question, Y, N, N/A. Rows include: PRIOR FILMS AVAILABLE, WAITING ON PRIOR FILMS, PRIOR REPORTS AVAILABLE, DREW PRIOR FILMS.