

MAMMOGRAPHY SCREEN FORM

Patient's name: _____ Date: _____

Address: _____

DOB: _____ SSN: _____

Email address: _____ Mobile phone: _____

- Have you had a prior Mammogram? YES NO If Yes, When _____ Where _____
- Are you PREGNANT now or is there a possibility that you could be pregnant? ? YES NO
- How many children have you had? _____ How old were you when you had your first child? _____
- Have YOU had Cancer of the _____ Breast _____ Uterus _____ Ovaries _____ Other _____ None
- Do you have a Family History of Cancer? YES NO If Yes, Mother's age at diagnosis _____
 Sister's age at diagnosis _____ Daughter's age at diagnosis _____ Maternal Grandmother's age at diagnosis _____
 Maternal Aunt's age at diagnosis _____ Maternal Cousin's age at diagnosis _____
- Any Male member of the family with diagnosis of Breast Cancer? YES NO If yes, relationship _____
- At what age did you start your periods? _____ Do you still have your periods? YES NO
- Have you had a hysterectomy? YES NO Do you take hormones? YES NO
- Are you having any NEW breast problems NOW? YES NO If YES, mark the problems below:



- 1. Distinct lumps in either breasts? RIGHT LEFT 3. Discomfort, pain or soreness? RIGHT LEFT
- 2. Lumpiness (fibrocystic changes)? RIGHT LEFT 4. Discharge from nipples? RIGHT LEFT

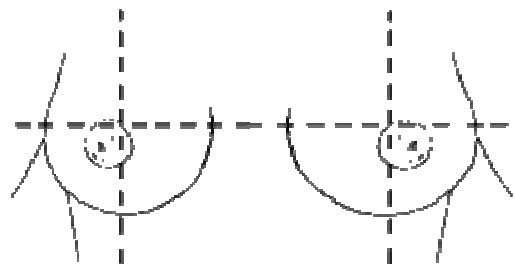
Please mark if you have previously had any of the Breast Procedures below YES NO

- 1. Needle biopsy- RIGHT LEFT When _____ 5. Reduction RIGHT LEFT When _____
- 2. Surgical biopsy RIGHT LEFT When _____ 6. Lumpectomy RIGHT LEFT When _____
- 3. Cyst aspiration RIGHT LEFT When _____ 7. Mastectomy RIGHT LEFT When _____
- 4. Implants When RIGHT LEFT _____ 8. Radiation RIGHT LEFT When _____

I hereby declare that the information provided in this form is true and complete to the best of my knowledge.

Patient's Signature: _____

Tech: _____ Rhonda Cain, RT(R)(M)



RIGHT

LEFT