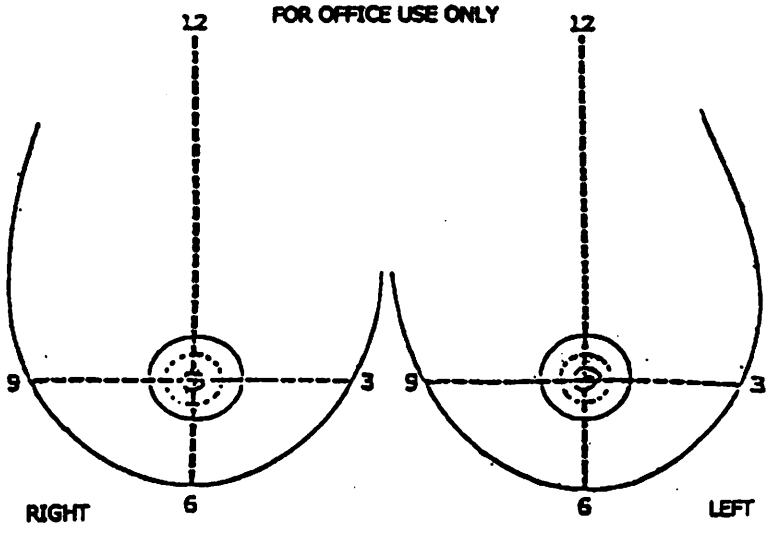
IT IS IMPORTANT TO FILL THIS FORM OUT COMPLETELY ON AN ANNUAL BASIS TO ASSIST THE RADIOLOGIST IN PROPERLY EVALUATING YOUR MAMMOGRAM. PLEASE DO NOT MARK ANY RESPONSE WITH "SAME AS LAST TIME". WE APPRECIATE YOUR COOPERATION.

FOR OFFICE USE ONLY



DOCTOR: _____

DATE: _____

PATIENT: _____

ADDRESS: _____

_____

HOME PHONE#: _____

WORK PHONE#: _____

NAME OF INSURANCE CO.: _____

D.O.B. _____/_____/_____

AGE:

SCAR MOLE THICKENING PAIN

REASON FOR MAMMOGRAM: _____ First symptom: _____/_____/_____

Ever had breast surgery: Yes ☐ No ☐ Ever had Radiation: Yes ☐ No ☐

If yes:

			Date of Procedure
implants	R ☐	L ☐	_____
mastectomy	R ☐	L ☐	_____
biopsy	R ☐	L ☐	_____
aspiration	R ☐	L ☐	_____
lumpectomy	R ☐	L ☐	_____
radiation	R ☐	L ☐	_____

Ever had a mammogram before _____

Where _____

When _____

MENSTRUAL HISTORY:

Age of onset _____

Age ended _____

Last period _____

CHILDBIRTH HISTORY:

No. of pregnancies _____

No. of deliveries _____

Age at 1st delivery _____

Are you on birth control pills:

Yes ☐ No ☐

If yes: Age at first use _____

Total Duration _____

Are you on female hormones:

Yes ☐ No ☐

If yes: Age at first use _____

Total Duration _____

FAMILY HISTORY:

Has any relative had breast cancer? Yes ☐ No ☐

If yes:

mother	☐	grandmother	☐
sister	☐	aunt	☐
daughter	☐	cousin	☐
niece	☐	self	☐