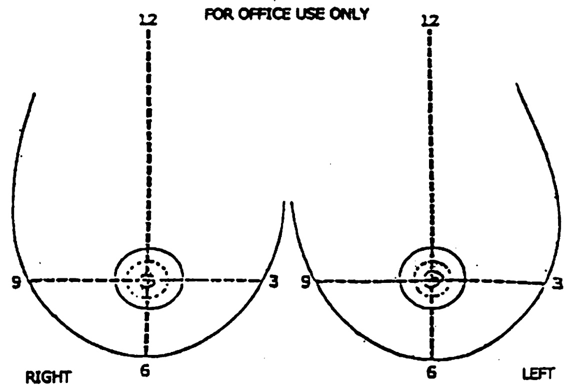
ALEXANDRIA WOMEN'S CENTER
MAMMOGRAPHY FORM

IT IS IMPORTANT TO FILL THIS FORM OUT <u>COMPLETELY</u> 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.



DOCTOR:______________________________

DATE:____/____/____

PATIENT: ______________________________

ADDRESS: ______________________________

____

HOME PHONE#: ______________________________

WORK PHONE#: ______________________________

NAME OF INSURANCE CO: ______________________________

BIRTH DATE:____/____/____

AGE:______________

REASON FOR MAMMOGRAM:______________________________ FIRST SYMPTOM:____/____/____

Ever had breast surgery: Yes ☐ No ☐
If yes:

	R		L	
Implants	R	☐	L	☐
Mastectomy	R	☐	L	☐
Biopsy	R	☐	L	☐
Aspiration	R	☐	L	☐
Lumpectomy	R	☐	L	☐
Radiation	R	☐	L	☐

Ever had radiation: Yes ☐ No ☐
Date of Procedure

____

____

____

____

____

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 ever had breast cancer? Yes ☐ No ☐
If yes:

Mother	☐	Grandmother	☐
Sister	☐	Aunt	☐
Daughter	☐	Cousin	☐
Niece	☐	Self	☐