



PAT0400

Mammography History Sheet

Exam Date: _____
 Last Name: _____ First: _____ MI: _____
 Street: _____ City: _____ State: _____
 Zip: _____ Date of Birth ____/____/____ Age ____ SSN _____
 Home Phone :(____) _____ Office Phone: (____) _____
 Patient's Doctor: _____ Last Visit: _____
 Last Mammogram exam: _____ Where? _____
 Under what name: _____ Physician at time: _____
 Date of last period: _____ Last breast exam: _____

KNOWN PATIENT DATA

PLEASE SIGN BELOW TO DOCUMENT THAT YOU ARE NOT PREGNANT

I authorize obtaining or releasing my breast health records for comparison and follow up.

Patient's Signature: _____ Date: _____

KNOWN REFERRING PHYSICIAN

Current Symptoms: _____ L=left, R=right, B=both

Lump: No Yes R L B When Noticed? _____
 Describe: _____

Nipple Discharge: No Yes R L B Color? _____

History:
 Hysterectomy No Yes When: _____ (age or year)
 Hormones: No Yes When: _____ (age or year)

Family History of breast cancer - check all that apply:

Personal history of breast cancer - Age _____
 Aunt, grandmother, cousin
 Mother, sister, daughter _____ pre-menopausal _____ post-menopausal

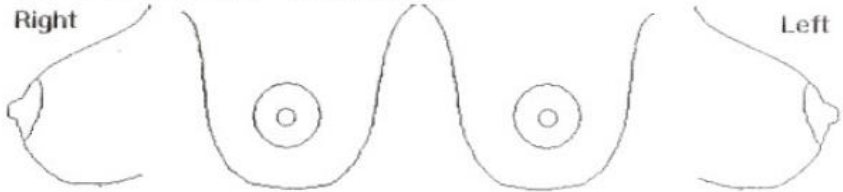
KNOWN MEDICAL HISTORY

Prior breast procedures: _____ L=left, R=right, B=both

Please indicate which breast & age or year done

Biopsy _____ R L B	Mastectomy _____ R L B
Implants _____ R L B	Lumpectomy _____ R L B
Reduction _____ R L B	Chemotherapy _____ R L B
Aspiration _____ R L B	Radiation _____ R L B

PLEASE DO NOT WRITE IN THIS SPACE:

Right  Left

KNOWN RISK FACTORS

Notes: _____

Technologist Signature: _____ Date _____

PREVIOUS PROCEDURES