

Y

MAMMOGRAPHY SPECIALISTS PATIENT HISTORY FORM

PATIENT NAME: _____

PLEASE CIRCLE Yes or No:

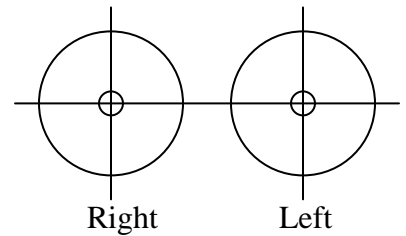
Have you ever had a mammogram before? Yes No

If Yes, date _____ Facility: _____

Would you like the doctor to give you the results immediately after your study if the doctor is available (an office consultation will be billed \$115)? Yes No

Do you feel any breast lump, mass or thickening on your own physical examination today? Yes No

If yes, describe and show where on diagram.



Do you have nipple discharge? Yes No
If yes, which side? Right Left

Do you have implants? Yes No

Are you pregnant? Yes No

Are you on any hormone replacement therapy (HRT) or birth control pills? Yes No

Have you **personally** had **breast cancer**? Yes No
If Yes, have you had radiation therapy? Yes No

Have you **personally** had any other type of cancer? Yes No
If Yes, what type? _____

Do you have a **family** history of **breast cancer**? Yes No Unknown
If Yes, who? _____ Age _____

Do you have any history of breast surgery? Yes No
If yes, which breast? _____ Year _____
What type of surgery? _____
(excisional biopsy, augmentation, reduction, cyst aspiration, core biopsy)

Tech Notes _____

Doctor Notes

SIGNED _____ DATE _____