

MAMMOGRAPHY SPECIALISTS
PATIENT HISTORY FORM - MALE

PATIENT NAME _____

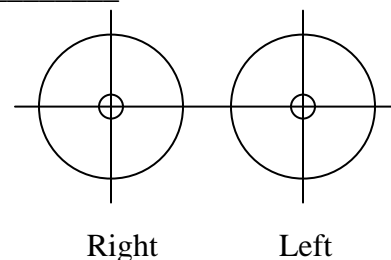
PLEASE CIRCLE YES OR NO:

Have you ever had a mammogram before? Yes No

If yes, date _____ Facility: _____

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

If yes, which side? Right Left



Describe and show where on diagram _____

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 _____

If yes, what type of surgery? _____
(Excisional Biopsy, Augmentation, Reduction, Cyst Aspiration, Core Biopsy)

Tech Notes

Doctor Notes

SIGNED _____ DATE _____