

Last Name	First Name	MI	DOB	Age	Sex <input type="checkbox"/> F <input type="checkbox"/> M	Self-Referred? <input type="checkbox"/> YES <input type="checkbox"/> NO
Doctor		Doctor Address			Doctor Phone	

PATIENT HISTORY FORM - MAMMOGRAPHY

First Mammogram Time since last mammogram ____ yrs ____ mos <1 mo Location: _____

Have you had the following? <input type="checkbox"/> History of breast cancer At age? ____ <input type="checkbox"/> History of other cancer At age? ____ Type _____ Treatment _____	FAMILY history of BREAST Cancer: (Blood Relative) <input type="checkbox"/> Mother <input type="checkbox"/> Daughter <input type="checkbox"/> Sister <input type="checkbox"/> Grandmother P/M <input type="checkbox"/> Aunt P/M <input type="checkbox"/> Father <input type="checkbox"/> Son <input type="checkbox"/> Brother <input type="checkbox"/> Grandfather P/M <input type="checkbox"/> Uncle P/M <input type="checkbox"/> BRCA gene <input type="checkbox"/> Ashkenazi Jewish <input type="checkbox"/> Other (non-immediate family member)
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Gynecological History: <u>Currently Pregnant?</u> <input type="checkbox"/> NO <input type="checkbox"/> YES Still In Menses? <input type="checkbox"/> NO <input type="checkbox"/> YES, Last Menstrual Period _____ Menopause? <input type="checkbox"/> NO <input type="checkbox"/> YES, At age ____ Hysterectomy? <input type="checkbox"/> NO <input type="checkbox"/> YES, At age ____ # of Live Births ____	Hormones: Are you currently taking hormones? <input type="checkbox"/> NO <input type="checkbox"/> YES Type: _____ Duration: _____ Birth Control: <input type="checkbox"/> NO <input type="checkbox"/> YES Type: _____
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Race/Ethnicity: Hispanic African American Caucasian Other (specify): _____

Smoking History: <input type="checkbox"/> Current every day smoker <input type="checkbox"/> Current some day smoker <input type="checkbox"/> Former smoker <input type="checkbox"/> Never smoker <input type="checkbox"/> Unknown if ever smoked <input type="checkbox"/> Smoker, current status unknown <input type="checkbox"/> Heavy tobacco user <input type="checkbox"/> Light tobacco user	Breast Surgical and Treatment History: List any procedures you may have had: result breast biopsy, excision, aspiration, cyst removal, lumpectomy, mastectomy, reduction, breast implants, other. Include date, type, side and result. ▶ Current Symptoms/Complaints/Concerns: ▶
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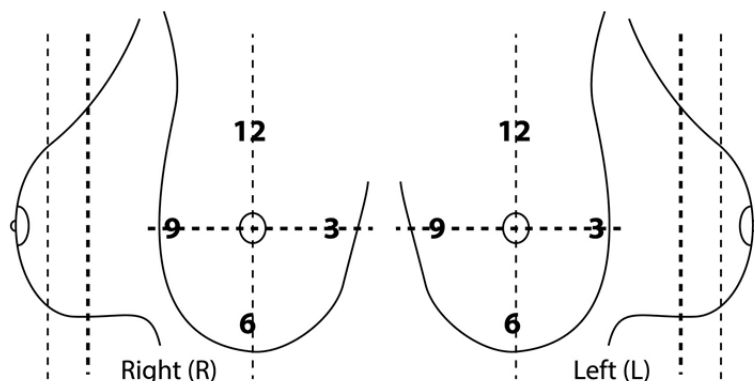
FOR TECHNOLOGIST USE ONLY:

Type: Screening Diagnostic Side: R L B Date: _____ Tech: _____

SCREENING CODE: 77067-3D 77067 OTHER: _____ **DIAG CODE:** 77066-3D 77066 77065-3D 77065 OTHER: _____

Views: _____ #TOMO: _____ BASELINE TECH REPEAT

Routine Views Special Views Implant Disp. Digital 3D



Comments: