Mammogram Information Sheet

Name: _____ **Age:** _____ **Date of Birth:** _____**Phone#:** _____

Mailing Address: _____

Referring Physician: _____ **Patient ID:** _____

Date of last mammogram: _____ **Location of last mammogram:** _____

BREAST SYMPTOMS

☐ I do not have any new breast symptoms

			How Long
☐ New breast lump	☐ Right	☐ Left	_____
☐ Focal breast pain	☐ Right	☐ Left	_____
☐ Nipple retraction	☐ Right	☐ Left	_____
☐ Nipple discharge	☐ Right	☐ Left	_____

Color: Red/ Brown/ Green/ Clear/ Milky

Spontaneous: NO / YES

☐ Other: _____

BREAST PROCEDURES

		YEAR
Reduction	☐ Right ☐ Left	_____
Implants	☐ Right ☐ Left	_____
Cyst Aspiration	☐ Right ☐ Left	_____
Needle biopsy	☐ Right ☐ Left	_____
Surgical excision - benign	☐ Right ☐ Left	_____
Surgical excision - cancer	☐ Right ☐ Left	_____
Mastectomy	☐ Right ☐ Left	_____
Radiation	☐ Right ☐ Left	_____
Chemotherapy		_____

BREAST HISTORY

Have you had breast cancer? ☐ No ☐ Yes - Age at diagnosis: _____ Type of cancer: _____

Family history of breast cancer? ☐ No ☐ Yes - Specify Mother, Sister, Daughter & age_____

Abnormal genetic testing? ☐ No ☐ Yes - Specify results: _____

Any other type of cancer? ☐ No ☐ Yes - Specify type: _____

Have you ever taken hormones? ☐ No ☐ Yes - Date started _____If no longer taking, stop date: _____

Are you pregnant? ☐ No ☐ Yes

Are you breastfeeding? ☐ No ☐ Yes

PATIENT SIGNATURE: _____ **DATE:** _____

By signing this form, I acknowledge the above information to be accurate and complete. I authorize this institution to obtain or release my breast imaging records for comparison or follow up.

---------- BELOW THIS LINE IS FOR TECHNOLOGIST ----------

EXAM TYPE: ☐ Screening ☐ Diagnostic Symptomatic ☐ Diagnostic Call Back ☐ Follow up

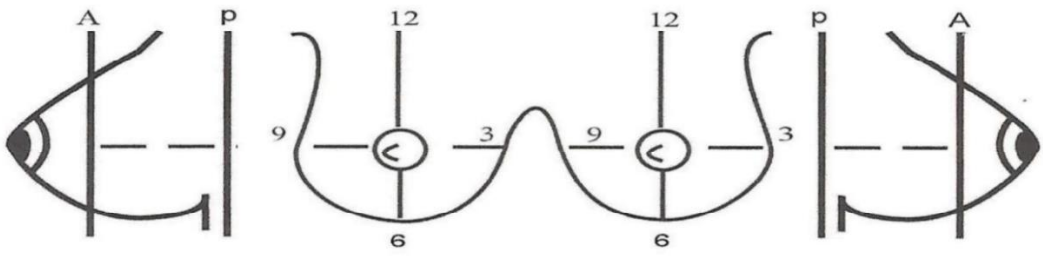
Was ultrasound performed? ☐ Yes ☐ No **Tech Initials:** _____ **Number of Images:** _____

Technologist's notes:

_____

_____

If the exam is for a palpable lesion, mark the palpable abnormality with a Δ in two views on the diagram. If a unilateral exam, cross out the breast that is not imaged. Mark all surgical scars on the diagram.



Δ Palpable

-/-/-/- Scar

O Mole