Patient Name: _____ DOB: _____

Have you ever had a mammogram? (Select One) ☐ Yes ☐ No

If yes, please supply the name, address, and phone number of the facility:

_____

_____

Are you pregnant now or any possibility? ☐ Yes ☐ No

PRIOR BREAST PROCEDURES

- Biopsy ☐ Right ☐ Left Date: _____
- Implants ☐ Right ☐ Left Date: _____
- Cystic Fluid Removed ☐ Right ☐ Left Date: _____
- Lumpectomy (Benign) ☐ Right ☐ Left Date: _____
- Lumpectomy (Malignant) ☐ Right ☐ Left Date: _____
- Mastectomy ☐ Right ☐ Left Date: _____
- Reduction ☐ Right ☐ Left Date: _____

Did you have radiation therapy? ☐ **Yes** ☐ **No** **If Yes, Explain:** _____

Do you have a family history of breast cancer? ☐ **Yes** ☐ **No** ☐ **Unknown**

If yes, what was their age? _____

☐ **Self** ☐ **Daughter** ☐ **Sister** ☐ **Mother** ☐ **Aunt** ☐ **Grandmother**

Do you take hormone therapy? ☐ **Yes** ☐ **No** **If Yes, Explain:** _____
Hormones/Birth Control ☐ **Yes** ☐ **No** **How Long?** _____
Tamoxifen ☐ **Yes** ☐ **No** **How Long?** _____
*If you have taken hormone replacement in the past & stopped, when did you stop? _____

Do you have any new problems with your breast's present day? ☐ **Yes** ☐ **No**

Mass or Lump ☐ Right ☐ Left
Discharge ☐ Right ☐ Left
Enlargement/Swelling ☐ Right ☐ Left
Pain/Soreness ☐ Right ☐ Left

If Yes, Explain Symptoms: _____

Technologist Comments: _____

Would you like instructions on breast self-exams? ☐ Yes ☐ No

****Continue to Next Page**

I agree that the information is accurate to the best of my knowledge.

Signature: _____ Date: _____