Imaging Specialists

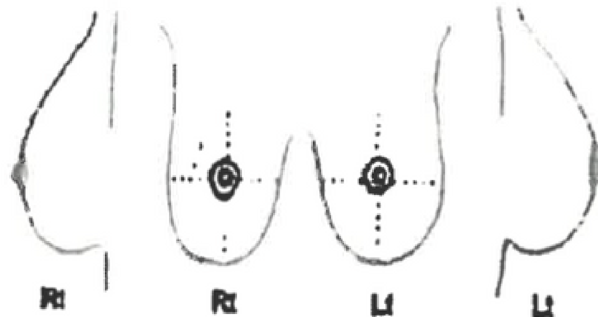
NAME: ______ DOB: ______ AGE: ______
HT: ______ WT: ______

MAMMOGRAM HISTORY FORM

PLEASE CHECK

| YES | NO | Do you have any current breast complaints or problems?

Indicate below any scars, lumps, moles, and/or areas of concern:



	RIGHT	LEFT
☐ Scars	____	____
☐ Lump or Mass	____	____
☐ Moles	____	____
☐ Tissue Thickening	____	____
☐ Skin Thickening/Retraction	____	____
☐ Nipple Discharge	____	____
☐ Nipple Inversion/Retraction	____	____
☐ Pain	____	____
☐ Other ______	____	____

YES	NO	Have you had a mammogram before? Location: ______ Date: ______	
YES	NO	Are you taking Birth Control or on Hormones (HRT)?	**BRCA TESTING:**
YES	NO	Are you currently pregnant and/or breastfeeding?	BRCA 1 ☐ +/-
		Your age at the birth of your first child? ______	BRCA 2 ☐ +/-
		Age of first cycle ______ Date of the beginning of your last period, or ______ Date of Menopause, or ______ Date of your Hysterectomy ______	**DO YOU HAVE BREAST IMPLANTS?** **YES / NO**
YES	NO	Have you or anyone in your family ever had breast cancer? ☐MYSELF at age ____ ☐ MOTHER at age ____ ☐ SISTER at age ____ ☐ DAUGHTER at age ____ ☐ AUNT at age ____ ☐ GRANDMOTHER at age ____	☐ Don't know
YES	NO	Have you had Breast Cancer? Type of Treatment: ☐Radiation ☐Chemotherapy☐Surgery	
YES	NO	Have you ever had breast surgery? IF YES, SEE BELOW.	

IF YOU ANSWERED YES TO THE QUESTION ABOVE, PLEASE INDICATE DATE, REASON FOR SURGERY, AND TYPE OF SURGERY BELOW:

	RIGHT	Date, reason, Benign or Malignant	LEFT	Date, reason, Benign or Malignant
Surgical Biopsy	RIGHT		LEFT	
Needle Biopsy	RIGHT		LEFT	
Cyst Aspiration	RIGHT		LEFT	
Lumpectomy	RIGHT		LEFT	
Mastectomy	RIGHT		LEFT	
Breast Implants	RIGHT		LEFT	
Breast Reduction	RIGHT		LEFT	

Patient Signature: ______ Date: ______

Tech Initials: ______