

Place patient sticker here

Contact number for results/follow-up:

Family History of Breast Cancer

(If **NO** cancer has been in your family leave lines blank)

Maternal: Mother's age _____
Daughter's age _____
Sister's age _____
Other's age _____

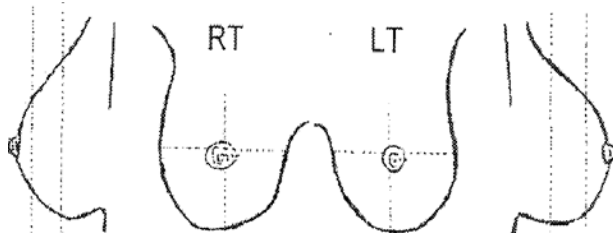
A. Have you been diagnosed with Cancer: Yes No
Please Circle:
Ovarian-Cervical-Uterine-Endometrial-Colon

B. What was your age at the time of your first menstrual period? _____

C. What was your age at the time of your first live birth of a child? _____ (If never given birth write "0" on line above or if you have adopted children write adopted.)

D. What is the your race/ethnicity?
Circle ONE:
White, African American, Hispanic, American Indian, Alaskan Native, Unknown or Asian American
IF Asian American please choose sub race\ethnicity:
Circle ONE:
Chinese, Japanese, Filipino, Hawaiian, Other Pacific Islander, Other Asian American

Technologist's remarks:



Tech Initials: _____

Number of Films: _____

Mammography History



Please circle your answers:

1.) Do you or your Dr. feel a new lump in your breast today.....Yes No
If yes is it.....Right or Left or Both

Indicate lump(s) location(s) above on Diagram:

2.) Do have any other problems with your breast today?.....Yes No
What kinds of Problems? _____

3.) Have you ever had **breast cancer**?.....Yes No
Date(s) _____ (circle) RIGHT LEFT or BOTH

Radiation: Yes or No

Chemo: Yes or No

DCIS Yes or No

LCIS Yes or No

Mastectomy.....Right Left Dates(s) _____

Lumpectomy..... Right Left Dates(s) _____

ReconstructionRight Left Dates(s) _____

Reduction Dates(s) _____

Type of reconstruction: Tram Flap or Implant or Other _____

4.) Have you had surgery on your breasts that was benign?.....Yes No
Biopsy..... Right Left Date(s) _____
Reduction..... Right Left Date(s) _____
Lift..... Right Left Date(s) _____

4a. Have you ever had at least one breast biopsy with atypical hyperplasia?
Yes or No

5.) Do you have implants?.....Yes No
Circle: Saline or Silicone

6.) Are you taking hormones or birth control pills?.....Yes No
How Long _____ Type _____

7.) Is this your first Mammogram?.....Yes No
If no, where were your old films done?
FACILITY NAME _____ YEAR _____

CITY AND STATE _____

8.) Are you pregnant?.....Yes No

I have read this information regarding my mammogram examination find it correct.

X _____

FOR OFFICIAL USE:

LIFETIME PERCENTAGE _____%