Women's imaging specialists

Today's Date: _____/_____/_____

Patient Name: _____

Date of Birth: _____/_____/_____

Mammography History Sheet

Are you currently pregnant or breast feeding? YES NO
Have you ever had a mammogram? YES NO
If YES - Place of last Mammogram: _____Date of Last Mammogram: _____/____/_____
How old were you when you had your first child? _____
How many times have you been pregnant? _____
How many children have you given birth to? _____
How old were you when you had your first menstrual cycle? _____
When was your last menstrual cycle? _____
Have you had a hysterectomy? ___YES ___NO If yes, how old were you? _____
Have you had your ovaries removed? ___YES ___NO If yes, how old were you? _____
Have you started menopause ___YES ___NO If yes, how old were you? _____

Do you have a palpable mass in your breast? YES NO If yes, Which Breast? _____
Do you have any breast pain? YES NO If yes, Which Breast? _____

Personal History:
Do you perform monthly breast self-exams? YES NO
Do you have breast implants? YES NO

Family History of Breast or Ovarian cancer (please specify which one):

_____No family history of breast cancer or ovarian cancer		
_____Mother	Ovarian or Breast Cancer (circle one)	age at diagnosis: _____
_____Sister	Ovarian or Breast Cancer (circle one)	age at diagnosis: _____
_____Daughter	Ovarian or Breast Cancer (circle one)	age at diagnosis: _____
_____Aunt → _____Maternal _____Paternal	Ovarian or Breast Cancer (circle one)	age at diagnosis: _____
_____Grandmother → _____Maternal _____Paternal	Ovarian or Breast Cancer (circle one)	age at diagnosis: _____

Have YOU been diagnosed with any of the following?

Breast cancer	____YES ____NO	Endometrial cancer	____YES ____NO
Colon cancer	____YES ____NO	Ovarian cancer	____YES ____NO

Are YOU currently taking any of the following?

Hormone therapy	____YES ____NO	If yes how long have you been taking them? _____
Contraceptives (birth control)	____YES ____NO	If yes how long have you been taking them? _____
Tamoxifen therapy	____YES ____NO	
Radiation therapy	____YES ____NO	
Chemotherapy	____YES ____NO	

Have YOU ever had any of the following?

Breast cancer with a lumpectomy	____YES ____NO	If yes when did you have the surgery? _____
Breast cancer with a mastectomy	____YES ____NO	If yes when did you have the surgery? _____
A needle biopsy	____YES ____NO	If yes when did you have the surgery? _____
Breast reduction	____YES ____NO	If yes when did you have the surgery? _____

Technologist Initials: