



DIAGNOSTIC MAMMOGRAPHY CLINICAL INFORMATION

For Office Use Only
Place Patient ID label here

Patient name _____ Age _____ Female Male
Reason for exam _____ Exam date _____

Y N Have you had previous mammograms? If yes, when and where? _____

Y N To the best of your knowledge, are you pregnant?

Y N Do you have a personal or family history of breast cancer? If yes, please explain. _____

Y N Are you currently taking hormones? If yes, what type? _____

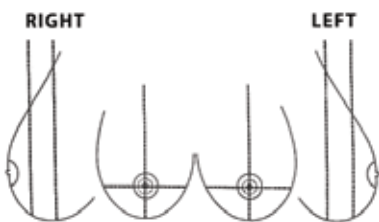
Present complaints. *If yes, please indicate right (R) or left (L) breast.*

<input type="radio"/> Y <input type="radio"/> N Lump(s) or swelling	<input type="radio"/> R <input type="radio"/> L	Onset of complaint	_____
<input type="radio"/> Y <input type="radio"/> N Pain, discomfort, soreness	<input type="radio"/> R <input type="radio"/> L		_____
<input type="radio"/> Y <input type="radio"/> N Nipple retraction, discharge or bleeding	<input type="radio"/> R <input type="radio"/> L		_____
<input type="radio"/> Y <input type="radio"/> N Other _____	<input type="radio"/> R <input type="radio"/> L		_____

Have you had any of the following breast procedures? *If yes, please indicate right (R) or left (L) breast.*

		When	Results
<input type="radio"/> Y <input type="radio"/> N Biopsy	<input type="radio"/> R <input type="radio"/> L	_____	_____
<input type="radio"/> Y <input type="radio"/> N Resection (i.e., lumpectomy)	<input type="radio"/> R <input type="radio"/> L	_____	_____
<input type="radio"/> Y <input type="radio"/> N Radiation	<input type="radio"/> R <input type="radio"/> L	_____	_____
<input type="radio"/> Y <input type="radio"/> N Breast Implants	<input type="radio"/> R <input type="radio"/> L	_____	_____
<input type="radio"/> Y <input type="radio"/> N Breast Reduction	<input type="radio"/> R <input type="radio"/> L	_____	_____
<input type="radio"/> Y <input type="radio"/> N Mastectomy	<input type="radio"/> R <input type="radio"/> L	_____	_____

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Remarks: _____

Technologist: _____ Date: _____