



SCREENING MAMMOGRAPHY PATIENT HISTORY

For Office Use Only
Place Patient ID label here

Patient name _____ Age _____ Female Male

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 history of breast surgery, biopsy **OR** implants? If yes, what type, which breast, and what year?

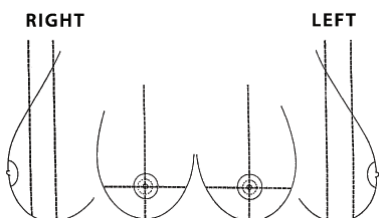
Y N Do you have a personal history of breast cancer? If yes, which breast, what year, and did you receive chemotherapy and/or radiation?

Y N Do you have a family history of breast cancer? If yes, who and at what age was the diagnosis?

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

Y N Do you currently have a breast lump or nipple discharge? If yes, please explain.

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Remarks: _____

Technologist: _____ Date: _____