



For Office Use Only  
Place Pt ID label here

### Diagnostic Mammography Clinical Information

Patient's Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Reason for today's exam? \_\_\_\_\_

Yes  No Previous mammograms? If yes, when and where: \_\_\_\_\_

Yes  No To the best of your knowledge, are you pregnant?

Yes  No Do you have a personal or family history of breast cancer? If yes, please explain. \_\_\_\_\_

Yes  No Are you currently taking hormones? If yes, what type? \_\_\_\_\_

Present complaints. *Please check those that apply and indicate right or left breast.*

	No	Right Breast	Left Breast	Onset of Complaint
Lump(s) or swelling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Pain, discomfort, soreness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Nipple retraction	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Nipple discharge/bleeding	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Other _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____

Have you had any of the following breast procedures? *Please check those that apply and indicate right or left breast.*

	No	Right Breast	Left Breast	When	Results
Biopsy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Resection (i.e. lumpectomy)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Radiation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Breast Implants	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	(Type) _____
Breast Reduction	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Mastectomy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____



WASHINGTON  
RADIOLOGY  
ASSOCIATES, P.C.

DIAGNOSTIC MAMMOGRAPHY CLINICAL INFO.

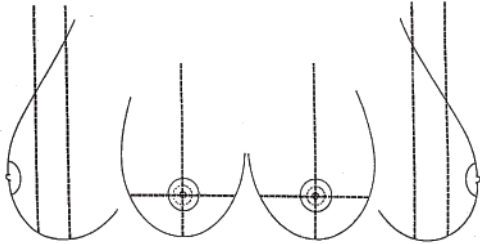


DO NOT WRITE BELOW THIS LINE

Right

Left

Remarks:



Tech