Washington Radiology Associates, P.C.

Screening Mammography Patient History

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Screening Mammography Patient History

Patient's Name ______________________________ Date ______________

◯ Yes ◯ No Previous mammograms? If yes, when and where: ______________________________

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

◯ Yes ◯ No Do you have a history of breast surgery, biopsy OR implants? If yes, what type, which breast, and what year? ______________________________

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◯ Yes ◯ No Do you have a personal history of breast cancer? If yes which breast, which year and did you receive chemo or radiation? ______________________________

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◯ Yes ◯ No Do you have a family history of breast cancer? If yes, who and at what age was the diagnosis?

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◯ Yes ◯ No Are you currently taking hormones? If yes, what type? ______________________________

◯ Yes ◯ No Do you currently have a breast lump or nipple discharge? If yes, please explain

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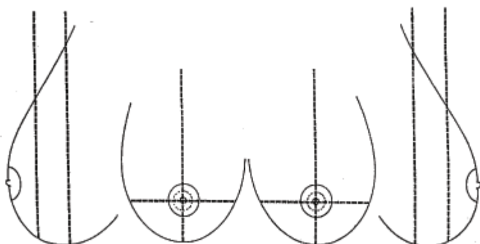
DO NOT WRITE BELOW THIS LINE



Remarks: ______________________________

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Tech ______________________________