Central Utah Imaging Mammography History Form

Name	Age Date of Birth
Referring Phys	icianToday's date
Date of Last Mei	nstrual PeriodNumber of pregnanciesAge of first pregnancy
□YES □NO	Are you taking any hormones or birth control pills? If yes, how long?
□ YES □ NO	Have you ever had breast cancer? If yes, Right Left When?
	How was it treated? Surgery Radiation Chemotherapy Tamoxifin
□ YES □ NO	Have any blood relatives ever had breast cancer? If yes, at what age did it occur? MotherSister(s)GrandmotherAuntsOther
□YES □NO	Do you have any lumps? If yes, are they (Check all that apply) Old New Both Which breast? Right Left Is your lump:(Check all that apply) Tender Enlarging Shrinking Not changing
□ YES □ NO	Do you have nipple discharge? If yes, indicate the color of the discharge: Bloody Green White Clear Cloudy Other
□ YES □ NO	Do you have any moles or skin lesion on you breast? Which breast?
□ YES □ NO	Have you ever had a mammogram before? If yes: Where? When?
□YES □ NO	Have you ever had breast surgery? (If yes, check all that apply below) Year
	□ YES □ NO Breast biopsy □ R □ L □ □ YES □ NO Lump removed □ R □ L □ □ YES □ NO Breast Removed □ R □ L □ □ YES □ NO Radiation Therapy □ R □ L □ □ YES □ NO Breast Reduction □ R □ L □ □ YES □ NO Breast Implants □ R □ L □ □ YES □ NO Cyst(s) drained □ R □ L □
Please initial after	reading:
I understand that	10% to 20% of all breast cancers are not visualized on mammogramsInitials
I will be responsib	e to follow up with my health care provider regarding all future breast concernsInitials
20% of screening	mammograms may need to return for additional evaluation.
☐ Advised pt. to s	inform provider of mammography performed. seek clinical breast exam from provider. noted by the pt. at time of imaging Tech initials
Screer	Right Left
	scar O palpable lump skin lesion/mole /// thickening pai