Central Utah Imaging

Mammography History Form

Name _____ Age_____ Date of Birth_____

Referring Physician_____ Today's date_____

Date of Last Menstrual Period_____ Number of pregnancies____ _Age 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?
Mother_____Sister(s)_____Grandmother_____Aunts_____Other_____

☐ 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 mammograms. _____Initials

I will be responsible to follow up with my health care provider regarding all future breast concerns.___Initials

20% of screening mammograms may need to return for additional evaluation.

Technologist Use:
☐ Advised pt. To inform provider of mammography performed.
☐ Advised pt. to seek clinical breast exam from provider.
☐ No complaints noted by the pt. at time of imaging._____ Tech initials

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Screening Diagnostic