Revere Health
OB/GYN

Mammography History Form

Name _____ Age _____ Date of Birth _____

Referring Physician _____ Today's date _____

Date of Last Menstration 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 _____ 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 Cloud Other _____

❑ YES ❑ NO Do you have any moles or skin lesion on your breast? Which breast? Right Left

❑ 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	Rediation Therapy	❑ R ❑ L	_____
❑ YES	❑ NO	Breast Reduction	❑ R ❑ L	_____
❑ YES	❑ NO	Breast Impants	❑ 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

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