Patient's Name _____ Date _____

Phone _____ Alternate Phone _____ Age _____ Date of Birth _____

	No	Yes
Is there any chance that you are pregnant?	___	___
Is this your FIRST mammogram?	___	___

If No, where did you have your last mammogram? _____ When? _____

Do you have a current breast problem?	No	Yes	Which Breast?	For How Long?
Breast Pain	___	___	R _____ L _____	_____
Palpable Lump or Thickening	___	___	R _____ L _____	_____
Skin or Nipple Abnormality*	___	___	R _____ L _____	_____
Nipple Discharge*	___	___	R _____ L _____	_____

*Describe: _____

Other Problem, Describe: _____

Have you ever had any of the following breast procedures or surgeries?

	No	Yes	Which Breast?	When?
Needle Biopsy	___	___	R _____ L _____	_____
Surgical Biopsy	___	___	R _____ L _____	_____
Lumpectomy	___	___	R _____ L _____	_____
Mastectomy	___	___	R _____ L _____	_____
Breast Implants	___	___	R _____ L _____	_____
Breast Reduction	___	___	R _____ L _____	_____
Breast Reconstruction	___	___	R _____ L _____	_____

		No	Yes	Which Breast?	When?
Have you previously had breast cancer?		___	___	R _____ L _____	_____
If Yes, did you have:	Radiation?	___	___		
	Chemotherapy?	___	___		

Are you currently taking (circle answer): Estrogen Replacement Tamoxifen (Nolvadex) Birth Control Pills

	No	Yes
Have any of your closest blood relatives been diagnosed with breast cancer?	___	___
Have any of your closest blood relatives been diagnosed with ovarian cancer?	___	___

Relationship: _____ Age at diagnosis: _____

Relationship: _____ Age at diagnosis: _____

	No	Yes
Have you had a breast exam by a physician within the last year?	___	___

If Yes, when? _____

Were there any findings? _____

I have been instructed regarding the importance of breast self-examination, yearly clinical examination by a physician and routine screening mammography.

Patient Signature: _____

Below for Technologist notes only:

Tech Initials

Revision Code: 4.24.14