INFORMATION WORKSHEET MAMMOGRAPHY

Patient Name: _____ Date: _____
Date of Birth: _____ Age: _____ Sex: F:_____ M: _____
Address: _____
City: _____ State: _____ Zip: _____ E-Mail: _____
Cellular: ( )_____ Home: ( )_____ Work Phone: ( )_____ Ext.: _____

Ethnic Origin: White ☐ Black ☐ American Indian ☐ Caribbean Island ☐
Asian ☐ Pacific Islander ☐ Ashkenazi Jewish ☐ Hispanic ☐ Other: (Optional) _____

Is this your first mammogram ever?: Yes:____ No: ____ If you have had previous mammograms, where were they done?:
Date: _____

Referring Physician: Dr. _____

Personal History

Do you have breast implants? Y___ N___
Silicone Gel ___ Saline___ Combination ___
Have you had Breast Reduction? Y___ N___
Have you had Breast Lift? Y___ N___
Have you had Breast Surgery? Y___ N___
Results (circle one) Benign or Malignant

Mastectomy? Rt___ Lt___ Both ___ When? _____
Radiation Therapy? Rt___ Lt___ Both ___ When? _____
Chemotherapy? Rt___ Lt___ Both ___ When? _____

Indicated Problems (check all that apply):

____ None
Do you currently have:
____ Lump you can feel Rt_____ Lt _____
____ Nipple Abnormality/Discharge Rt_____ Lt _____
____ Pain Rt_____ Lt _____

If yes, to any of these, please explain:

_____
_____
_____
_____
_____

Medications:

____ None How Long?
Estrogen _____
Progesterone _____
Birth control pills _____
Tamoxifen _____
IUD Y___ N___ _____

Risk Profile:

Personal:

Age when menstruation began? ___ 7 - 11
___ 12 - 13
___ > 14
Age when menstruation stopped? _____
Date of last menstrual period? _____
Have you ever been pregnant? Y___ N___
How old were you when you delivered your first child?
_____
Have you had a breast biopsy? Rt___ Lt___ Both___
None___
Did biopsy show atypical hyperplasia? Y___ N___
Did biopsy show LCIS? Y___ N___
Personal history of breast cancer? Y___ N___
Age at diagnosis?_____
Personal history of ovarian cancer?
Age at diagnosis?_____
Personal history of cancer, other? _____
Have you had fertility treatment drugs? Y___ N___
If yes, number of times & when _____

Family:

1st Degree relative with BRCA gene testing done?
(mother/sister/daughter/father) Y___ N___
Test Result: BRCA 1 Positive___ Negative___
BRCA 2 Positive___ Negative___
Family history of breast cancer? Y___ N___
Who? _____
Age at diagnosis? _____
Family history of ovarian cancer? Y___ N___
Who? _____
Age at diagnosis? _____

To the best of my knowledge, I am not currently pregnant **Signature.** _____

Patient's Signature. _____ **Date.** _____

REVISED 07/2012