



Last Name: _____ First Name: _____ Date of Birth: _____
 Age: _____ Insurance: _____ Send copy of report to: _____

Do you live within 60 miles of this facility? YES NO

Is this your first mammogram? NO YES If NO, when/where was your last mammogram? _____
 Do you have implants? NO YES What type? _____ What year did you get them? _____
Answer the following questions, if applicable:
 Age of 1st Menstruation: _____ # of Children Birthed: _____
 Age of 1st Full Term Pregnancy: _____ # Breast Feed: _____
 Menopause Age: _____ Years Smoked: _____
 Age Ovaries Removed: _____ Patient Height: _____ Patient Weight: _____
 Age of Hysterectomy: _____

	Date or Age Onset	Date or Age Last Used	
Hormonal Contraceptives:	_____	_____	
Estrogen:	_____	_____	
Progesterone:	_____	_____	
Anti-Estrogen Drug:	_____	_____	
Last Menstrual Period:	_____		Any chance of being pregnant? <input type="checkbox"/> NO <input type="checkbox"/> YES
			Are you breastfeeding? <input type="checkbox"/> NO <input type="checkbox"/> YES

Personal breast cancer history? NO YES If YES, age of diagnosis? _____
 Any history of radiation therapy or chemo for breast cancer? NO YES
 Cancer elsewhere? NO YES If YES, what kind? _____
 BRCA 1 or 2 gene mutation? NO YES
 Family history of breast cancer? NO YES
 Family history of ovarian cancer? NO YES

If YES, list maternal or paternal (mother or father), relationship (mother, aunt, etc.) and age of their diagnosis below:

Relationship to you	Maternal	Paternal	Age of diagnosis?	Breast or ovarian cancer?

Any NEW breast symptoms (lump, focal pain, clear/bloody nipple discharge)? YES NO

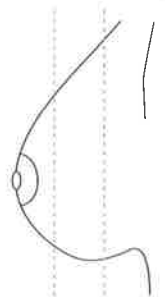
If YES, explain _____

Have you had any breast surgeries/biopsies? _____

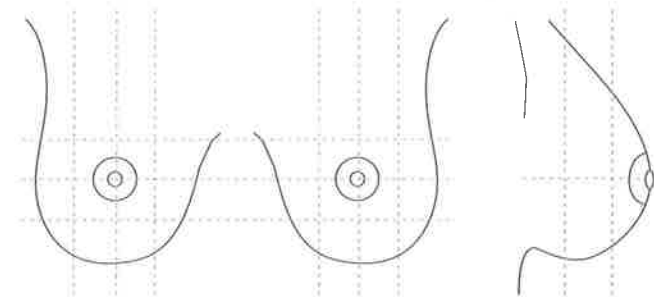
If your history indicates High Risk and your Physician approves, do you want to be referred for an assessment? YES NO _____ initials

Notes:

Right



Left



Patient Signature: _____ Date: _____ Technologist Initials: _____