



MAMMOGRAPHY WORKSHEET

FILE # _____ DATE: _____ Age: _____

Comprehensive Diagnostic Imaging & Radiology NAME: _____ Race: _____

Date of Birth: _____ Ref Physician: _____ Are You Pregnant: Y N

Routine Mammogram Today? Y N Reason: _____

Do You Have a: BREAST LUMP Y N If yes what side R L BOTH

DISCHARGE Y N If yes clear / milky / yellow / green / black
What Side R L BOTH

BREAST PAIN Y N If yes what side R L BOTH

PREVIOUS BREAST TESTS:

Mammogram: Date _____ Where? _____

Ultrasound: Date _____ Where? _____

Last time your doctor examined your breasts? Date: _____ Do you regularly examine your breasts? Y N

PREGNANCY: Total # Pregnancies _____ Total # Children _____ Miscarriages/Abortions _____

Age at First Live Birth: _____ History of Breast Cancer, DCIS or LCIS Y N

History of Atypical Hyperplasia Y N

Estrogen Therapy? Y N What? _____ When Started? _____

MENSTRUAL HISTORY: Age at first period: _____ Date of last period: _____

Age at menopause: _____ Ovarian/Uterine Surgery Y N

PREVIOUS BREAST SURGERY:

Implants Y N If yes what kind? Silicone / Saline

Breast reduction Y N If yes how long ago? _____

Biopsy Left Date: _____ Diagnosis: Benign / Malignant

Right Date: _____ Diagnosis: Benign / Malignant

Mastectomy / Lumpectomy Left Date: _____ Diagnosis: Benign / Malignant

Right Date: _____ Diagnosis: Benign / Malignant

Radiation therapy? Y N Chemotherapy? Y N

FAMILY HISTORY OF BREAST / UTERINE / OVARIAN CANCERS? Y N

If yes, please indicate age at detection, type of cancer, (P) paternal or (M) maternal side of family.

Mother _____ Father _____ Grandparent _____

Daughter _____ Aunts _____ Sisters _____

Others _____