# MAMMOGRAPHY WORKSHEET

☐ MRI ☐ TUCKAHOE ☐ NPI
☐ NMR

**MRN:**

| Last | First | MI | DOB |
|---|---|---|---|
| | | | |

| Home phone | Work phone x | Age |
|---|---|---|
| | | |

| Address |
|---|
| |

| City | State | Zip | ☐ Female ☐ Male |
|---|---|---|---|
| | | | |

| Referred by: | SSN: |
|---|---|
| | |

**REASON FOR TODAY'S MAMMOGRAM** ☐ **Routine**

☐ Right ☐ Left Lump (new or enlarging) __________
☐ Right ☐ Left Discharge from nipple __________
☐ Right ☐ Left Pain and/or soreness __________
☐ Right ☐ Left Other __________

**PREVIOUS HISTORY**

☐ Yes ☐ No Are you or could you be pregnant at this time?
☐ Yes ☐ No Have you breast fed within the past 4 months?
☐ Yes ☐ No Have you had a change in weight? ☐ Gain ☐ Loss How much? ______
☐ Yes ☐ No Are you currently on hormone therapy (Estrogen)? If yes, since when? ______
Have there been any changes? ______
☐ Yes ☐ No Have you ever been told you have breast cancer? ☐ ☐ Left Breast? Date of Diagnosis? ______
☐ Auxiliary node surgery ☐ Positive ☐ Negative # of Nodes: ______
☐ Radiation therapy? ☐ Chemotherapy?
☐ Yes ☐ No Have you ever been told you have the breast cancer gene?
☐ Yes ☐ No Do you have a history of ovarian cancer? If yes, what age at diagnosis? ______
☐ Yes ☐ No Do you have a history of endometrial cancer? If yes, what age at diagnosis? ______
☐ Yes ☐ No Do you have a history of colon cancer? If yes, what age at diagnosis? ______
☐ Yes ☐ No Do you have a history of a high-risk lesion? If yes, what age at diagnosis? ______
☐ Yes ☐ No Is there a history of breast cancer in your family? ☐ Mother - at Age ____ ☐ Grandmother-at Age ____
☐ Sister-at Age ____ ☐ Daughter-at Age ____ ☐ Aunt - at Age ____ ☐ Cousin - at Age ____
☐ Yes ☐ No Have you ever had a mammogram? If yes, complete below:
**Most Recent:** ______ **Where?** ______
**Date of next most Recent:** ______ **Where?** ______
**Date of next most Recent:** ______ **Where?** ______

| **PREVIOUS BREAST SURGERY** ☐ **None** | | | **When?** | **Where?** |
|---|---|---|---|---|
| ☐ Right | ☐ Left | Mastectomy | | |
| ☐ Right | ☐ Left | Lumpectomy for Cancer | | |
| ☐ Right | ☐ Left | Benign Surgical Biopsy | | |
| ☐ Right | ☐ Left | Stereotactic Biopsy | | |
| ☐ Right | ☐ Left | Cyst Aspiration | | |
| ☐ Right | ☐ Left | Implants | | |
| ☐ Right | ☐ Left | Reduction | | |

***The above information is correct. I authorize release of my prior mammograms to this facility.***

**Patient Signature:** ____________ **Date:** ______