



Home # \_\_\_\_\_ Cell # \_\_\_\_\_

**Why are you having this mammogram? (Mark one)**

- Screening (Routine)
- Lump or Thickening
- Skin Changes or Retraction
- Pain (Chronic or New)
- 3 or 6 Months Follow-Up
- Nipple Discharge (please note color of discharges \_\_\_\_\_)
- Breast Implant problem
- Spot Mags (Call Back Mammogram)

**Have you ever had a mammogram?** If yes, when: \_\_\_\_\_ where: \_\_\_\_\_  YES  NO

**Have you had any breast surgery or treatment? (Mark one)**  YES  NO

Procedures:                      Where:                      When:                      Results:

Biopsies                       Right  Left \_\_\_\_\_

Mastectomy                       Right  Left \_\_\_\_\_

Reduction                       Right  Left \_\_\_\_\_

Implants                       Right  Left \_\_\_\_\_       Saline  Silicon  Pre-Pectoral  Retro-Pectoral

**Have you or anyone in your family been diagnosed with breast cancer?**  YES  NO

- Myself
- Mother
- Sister
- Daughter
- Grandmother
- Aunt

At What Age? \_\_\_\_\_

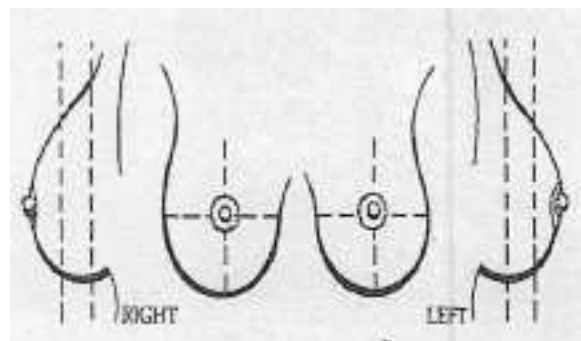
**Do you use hormone replacement therapy?**  YES  NO

**Are you pregnant?** \_\_\_\_\_

**Have you had a weight (increase/decrease) in the last year? If so, how much** \_\_\_\_\_  YES  NO

**Have you ever been tested for the breast cancer gene (BRCA1 or BRCA2)?**  YES  NO

**If you have been tested, do you have the breast cancer gene?**  YES  NO



Technologist Signature

Date

Time