Mammogram History

(Please DO NOT leave any question blank. We are aware that we may have this information in your chart, but are asking that you fill out this form in its entirety for something may have changed, Thank you)

Date: _____

Patient Name: _____DOB _____ AGE _____

Where and when was your last mammogram? _____

Where and when was your last breast ultrasound? _____

When was the last time your doctor did a Breast exam? _____

Are you having any NEW breast problems: Yes / No Which breast Left/ Right / Both

If you are having a problem what type: Solitary Lump / Nipple discharge / Pain / Armpit swelling

Have you ever had breast surgery? Yes / No Which breast Left/ Right / Both

Type of Surgery:
Biopsy Date _____
Implants Date _____
Reduction Date _____

Have you ever had breast cancer? Yes / No Which breast Left/ Right / Both

Lumpectomy? Yes / No Which Breast? Right / Left / Both
Mastectomy? Yes / No Which Breast? Right / Left / Both
Radiation Therapy? Yes / No Which Breast? Right / Left / Both
Chemotherapy? Yes / No

Date your surgery and/or treatment Started? _____

Do you have a family history of breast cancer? Yes / No

If so, indicate relative and age of diagnosis:
Mother at age _____ Sister at age _____ Daughter at age _____
Aunt at age _____ Grandmother at age _____

Are you CURRENTLY using hormones (pill, patch, injection?) Yes / No
If so, how long _____

Are you currently :
BEFORE menopause? Yes / No AFTER menopause? Yes / No
Pregnant? Yes / No Breastfeeding? Yes / No

Has your weight gone up or down more than 10 pounds over the last years? Yes / No