South Shore Obstetrics & Gynecology Women's Health Care

Mammography History

Name		MRN	
Age	Birthdate	Phone Number	
Address			
City		State	Zip
Primary Care Physician			

Have you had a mammogram in the past? ☐ No ☐ Yes Facility Date

Are you pregnant? ☐ No ☐ Yes

Are you taking hormone replacement therapy? ☐ No ☐ Yes How long?

Any new problems with your breasts? ☐ No ☐ Yes

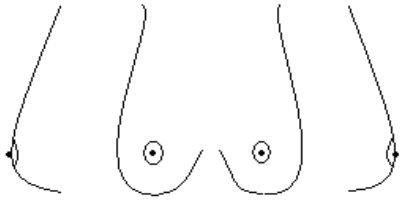
Have you had breast cancer? ☐ No ☐ Yes

Check all that apply:	RT	LT
Pain		
Discharge		
New lump		

Have you had a breast biopsy or surgery? ☐ No ☐ Yes

Please mark moles, scars, and surgery sites.

Right Left



Tech Comments	Tech:

Check all that apply:	RT	LT	Date
Breast implants			
Cyst aspiration			
Needle biopsy			
Surgical biopsy (not cancer)			
Lumpectomy (remove cancer)			
Radiation therapy			
Chemotherapy			
Mastectomy			
Reconstruction			
Breast reduction			
Other:			
Other:			

Have the following family members had breast cancer?

				Age Diagnosed	Comments
Mother	☐ No	☐ Yes	☐ I don't know		
Sister	☐ No	☐ Yes	☐ I don't know		
Daughter	☐ No	☐ Yes	☐ I don't know		
Other	☐ No	☐ Yes	☐ I don't know		

I authorize release of information, films, and copies pertinent to my medical history and for follow-up of any suspicious findings.

Patient Signature Date