

ULTRASOUND ASSOCIATES

Women's Imaging Center

PATIENT MAMMOGRAPHY INFORMATION

Name: _____ Age: _____ Date of Birth: _____

1. Have you ever had a mammogram before? NO _____ YES _____
Where: _____ When (Most Recent): ____/____/____
MO DAY YR
2. Are you or could you be pregnant? NO _____ YES _____
3. Are you or have you nursed in the last six months? NO _____ YES _____
4. Do you have a period every month? NO _____ YES _____
First Day of Last Period ____/____/____
MO DAY YR
5. Are you on estrogen replacement therapy? NO _____ YES _____
If yes, when did treatment start? ____/____/____
MO DAY YR
6. Have you had any of the following?
- a. Breast Implants NO _____ YES _____ When: ____/____
MO YR
 - b. Breast Reduction NO _____ YES _____ When: ____/____
MO YR
 - c. Breast Biopsy NO _____ YES _____ When: ____/____
MO YR
 - d. Personal History of Breast Cancer NO _____ YES _____ When: _____
YEAR
 - e. Radiation Treatments to your breasts NO _____ YES _____ When: _____
YEAR
7. **Since your last exam**, do you have any of the following?
- a. A lump or thickening in your breast NO _____ YES _____ WHERE: RT ____ LT ____
 - b. A bloody nipple discharge NO _____ YES _____ WHERE: RT ____ LT ____
 - c. A specific area of breast pain NO _____ YES _____ WHERE: RT ____ LT ____
 - d. Nipple abnormality (e.g. retraction) NO _____ YES _____ WHERE: RT ____ LT ____
8. Has your mother or a sibling been diagnosed with Breast Cancer? NO _____ YES _____ WHO: _____ AGE: _____

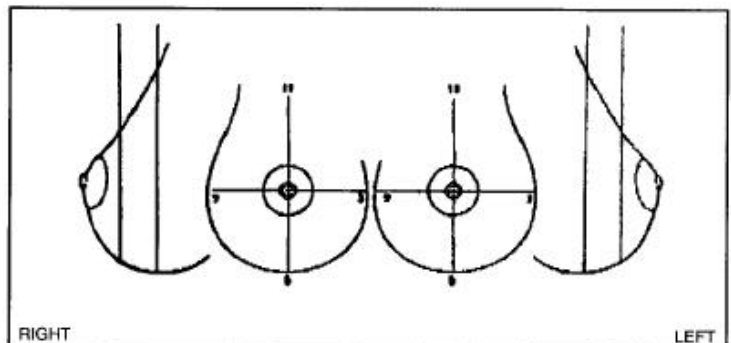
SIGNATURE

DATE

FOR OFFICE USE ONLY

History Reviewed

Detector Cleaned



Technologist