South Shore Health System

MAMMOGRAPHY PATIENT HISTORY SHEET

Last Name: _____ First Name: _____ Date of Birth: \ \

Home Phone: ( ) _____ Cell Phone: ( ) _____ May we leave a message? (Y / N)

Physician(s) to who reports will be sent: _____

Reason for Exam: ☐ Yearly Exam ☐ Follow-Up ☐ New Symptom ☐ First Mammogram

New Symptom (Please Describe) _____

_____

☐ Yes ☐ No Have you had a mammogram before?

Where? _____ When? _____

☐ Yes ☐ No Have you had a breast ultrasound before?

Where? _____ When? _____

FAMILY AND PERSONAL HISTORY

☐ Yes ☐ No Do you have a family history of breast cancer? If yes, in which relative(s)?

☐ Self, age _____ ☐ Mother, age _____ ☐ Grandmother, age _____ (Maternal or Paternal)

☐ Sister*, age _____ *How many sisters do you have? _____ ☐ Daughter, age _____

☐ Aunt, age _____ (Maternal or Paternal) ☐ Cousin, age _____ (Maternal or Paternal)

☐ Any Male relatives with breast cancer history?

☐ Yes ☐ No Family history of ovarian cancer? (Specify) _____

☐ Yes ☐ No Family history of pancreatic cancer? (Specify) _____

☐ Yes ☐ No Have you been treated with whole chest radiation for treatment of Lymphoma?

☐ Yes ☐ No Are you of Ashkenazi (Jewish) descent?

☐ Yes ☐ No Are you still having menstrual periods? **Date of last period:** _____ **Age at 1st period:** _____

☐ Yes ☐ No Have you had a hysterectomy? If yes, when: _____ Were your ovaries removed? _____

☐ Yes ☐ No Have you had a child? If yes, your age at your first child's birth: _____

Your age at your last childbirth: _____ Number of children: _____

☐ Yes ☐ No Have you taken hormone medications? Last date taken: _____

What type? ☐ Estrogen ☐ Progesterone ☐ Birth Control Pills ☐ Other

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☐ Yes ☐ No Have you had a Breast Biopsy Procedure (Stereotactic, Ultrasound biopsy, Surgical biopsy)

☐ Yes ☐ No Have you had any other type of breast surgery?

☐ Implants ☐ R ☐ L Date: _____

☐ Reduction ☐ R ☐ L Date: _____

☐ Mastectomy ☐ R ☐ L Date: _____

☐ Lumpectomy ☐ R ☐ L Date: _____

Patient Signature: _____ Date: _____

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TECHNOLOGIST NOTES — OFFICE USE ONLY

FOR TECHNOLOGIST USE ONLY

Has the patient ever had a breast biopsy? (list dates)

Left	Right	US Core	Stereo	MRI	BX	Surgical	Where	Results

Mastectomy R___ L___ Date: _____

Lumpectomy R___ L___ Date: _____ ReExcision? Date: _____

R___ L___ Date: _____ ReExcision? Date: _____

Chemotherapy? Y / N Radiation to breasts? R___ L___ Date: _____

What is your current weight? _____

What is your height? _____

Do you smoke? _____

Have you ever smoked? _____

How many years? _____

Deodorant?____ If yes, has it been removed?___

Does patient wear an infusion pump for insulin regulation?____

**May someone from our office contact you with further questions regarding your personal risk factors?____
Which number do you prefer? H / C _____