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[redacted]

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MAMMOGRAPHY HISTORY

Name _____ Todays Date _____

Referring Physician _____ Age _____

Do you or your doctor feel lumps in either breast? _____ **Right** **Left** **Where?** _____

Have you had previous mammograms? _____ **Where?** _____

Age at the time of first menstrual period. _____

Age at first live birth _____ Did you breast feed? _____

Do you regularly take birth control pills or hormones? _____

Do you have regular menstral periods? _____ If yes, date of last _____

Do you have discomfort, pain, or soreness? _____

Do you have discharge from nipples? _____ If yes, what color is it? _____

Have you lost or gained weight since last mammo exam? _____ How many pounds? _____

Have you had any breast surgery or biopsies or implants? _____ If yes describe _____

_____

Have you ever had radiation therapy? _____ For? _____

Is there a history of breast cancer in your family? _____ If yes, which relative?

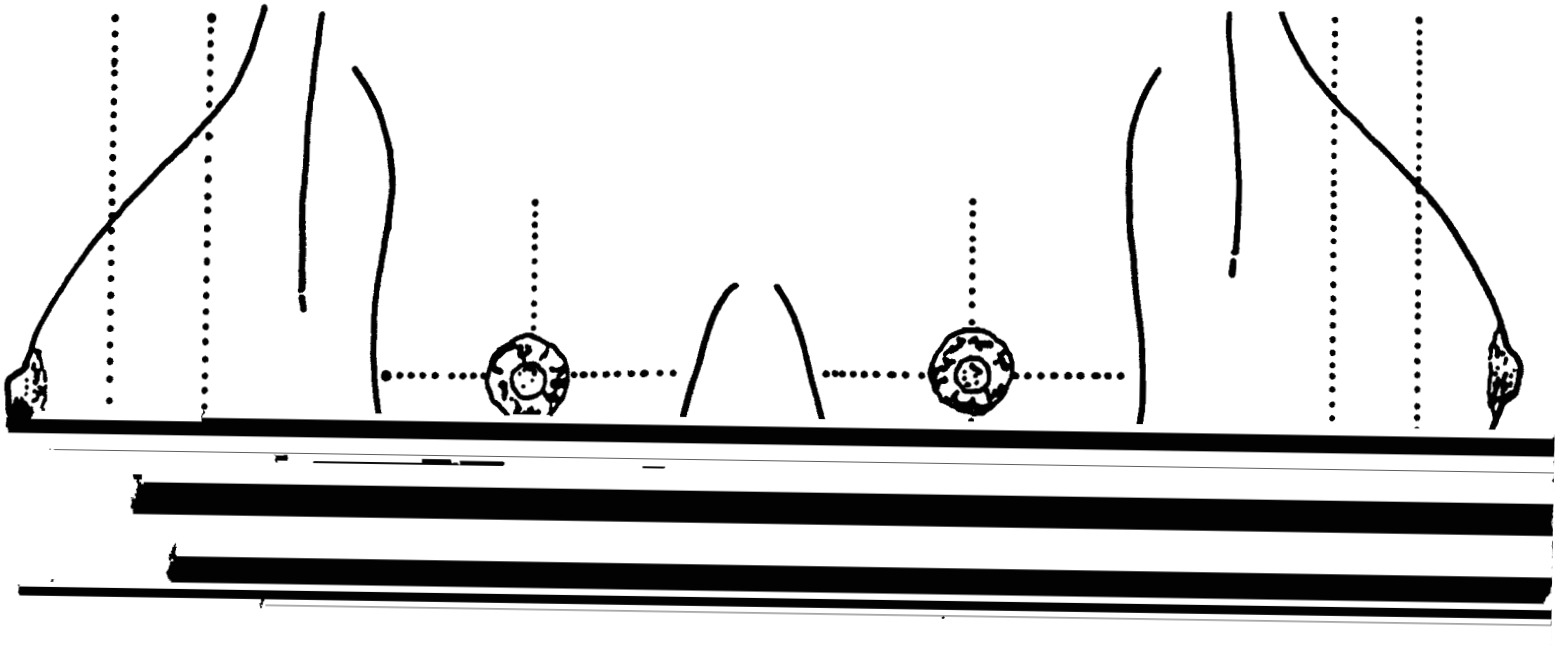
Mother _____ Age _____ Sister _____ Age _____ Daughter _____ Age _____

Aunt _____ Age _____ Grandmother _____ Age _____

Medications Currently Taking: _____

_____

Patientís Signature _____ Tech Signature _____



RIGHT **LEFT**