INFORMATION WORKSHEET MAMMOGRAPHY

Name:______________________________ Date:______________

Date of Birth:______________Age:______________Sex: F________M________

Address:______________________________

City______________State:______________Zip Code______________

Phone Number: (   )______________House Number:(   )______________

Social Security Number: ______________________________

Ethnic Origin: Caucasian________ African American ________American Indian/Eskimo ________Asian/Pacific Islander_______Hispanic_________

Is this you first mammogram ever? No ☐ Yes ☐ If yes, where were they done? ______________ When? __________

Referring physician: ______________________________

Medications: ( ) None How long?

- Estrogen ______________
- Progesterone ______________
- Birth Control Pills ______________
- Tamoxifen ______________
- Other? (Please List) ______________

Previous Treatment: ( ) None Date

Treatment				Date
Cyst Aspiration	Rt____	Lt _____	Both_____	__________
Reduction Surgery	Rt____	Lt _____	Both_____	__________
Needle Biopsy	Rt____	Lt _____	Both_____	__________
Excisional Biopsy	Rt____	Lt _____	Both_____	__________
Lumpectomy	Rt____	Lt _____	Both_____	__________
Mastectomy	Rt____	Lt _____	Both_____	__________
Radiation Therapy	Rt____	Lt _____	Both_____	__________
Chemotherapy	Rt____	Lt _____	Both_____	__________

History:

- Age when menstruation began? ______________
- Age when menstruation stopped? ______________
- Date of last menstrual period ______________
- Have you had your ovaries removed? No ☐ Yes ☐
- Have you had a hysterectomy? No ☐ Yes ☐
- Number of pregnancies ______________

Do you have implants: No ☐ Yes ☐

Silicone ☐ Saline ☐ Combination ☐

Pre-Pectoral (in front of muscle) ☐

Retro-pectoral (behind of muscle) ☐

Risk Factors (check all that apply) ( ) None

____ Family history of breast cancer
Who? ______________________________
Age at diagnosis______________________________
____ Personal breast cancer history
____ Personal history of cancer (uterus, ovaries, colon, etc.)
____ Family history of cancer (uterus, ovaries, colon, etc.)
Who?______________________________
____ History of LCIS
____ Post-menopausal patient
____ Nulliparous (no pregnancies)
____ Late child bearing (after 30)

Please indicate, on picture, location of current symptoms or previous surgery

LEFT RIGHT

Indicated Problems: (check all that apply) ( ) None

Do you currently have: Date:

Problem				Date
____ Palpable abnormality	Rt_____	Lt _____	Both_____	__________
____ Lump or thickening	Rt_____	Lt _____	Both_____	__________
____ Nipple abnormality	Rt_____	Lt _____	Both_____	__________
____ Pain or thickening	Rt_____	Lt _____	Both_____	__________
____ Skin thickening	Rt_____	Lt _____	Both_____	__________
____ Large axillaries lymph nodes	Rt_____	Lt _____	Both_____	__________
____ Nipple discharge	Rt_____	Lt _____	Both_____	__________
____ Cancer elsewhere (please indicate)	______________________			

To the best of my knowledge, I am not currently pregnant No ☐ Yes ☐

Signature:______________________________ **Date:**______________________