



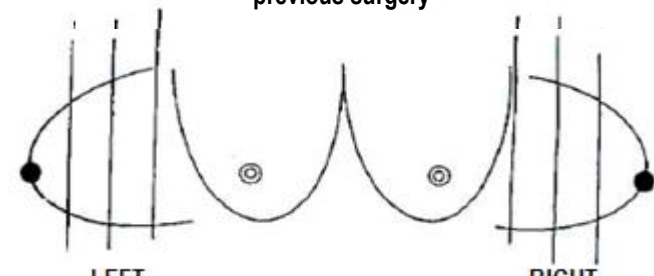
## INFORMATION WORKSHEET MAMMOGRAPHY

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 your first mammogram ever? No  Yes  If yes, where were they done? \_\_\_\_\_ When? \_\_\_\_\_  
 Referring physician: \_\_\_\_\_

<b>Medications:</b> ( ) None How long? Estrogen _____ Progesterone _____ Birth Control Pills _____ Tamoxifen _____ Other? (Please List) _____	<b>Previous Treatment:</b> ( ) None 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 _____
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<b>History:</b> Age when menstruation began? _____ Age when menstruation stopped? _____ Date of last menstrual period _____ Have you had your ovaries removed? No <input type="checkbox"/> Yes <input type="checkbox"/> Have you had a hysterectomy? No <input type="checkbox"/> Yes <input type="checkbox"/> Number of pregnancies _____	<b>Do you have implants:</b> No <input type="checkbox"/> Yes <input type="checkbox"/> Silicone <input type="checkbox"/> Saline <input type="checkbox"/> Combination <input type="checkbox"/> Pre-Pectoral (in front of muscle) <input type="checkbox"/> Retro-pectoral (behind of muscle) <input type="checkbox"/>
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<b>Risk Factors</b> (check all that apply) ( ) None <input type="checkbox"/> Family history of breast cancer Who? _____ Age at diagnosis _____ <input type="checkbox"/> Personal breast cancer history <input type="checkbox"/> Personal history of cancer (uterus, ovaries, colon, etc.) <input type="checkbox"/> Family history of cancer (uterus, ovaries, colon, etc.) Who? _____ <input type="checkbox"/> History of LCIS <input type="checkbox"/> Post-menopausal patient <input type="checkbox"/> Nulliparous (no pregnancies) <input type="checkbox"/> Late child bearing (after 30)	<b>Please indicate, on picture, location of current symptoms or previous surgery</b> 
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<b>Indicated Problems: (check all that apply)</b> Do you currently have: <input type="checkbox"/> Palpable abnormality <input type="checkbox"/> Lump or thickening <input type="checkbox"/> Nipple abnormality <input type="checkbox"/> Pain or thickening <input type="checkbox"/> Skin thickening <input type="checkbox"/> Large axillaries lymph nodes <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Cancer elsewhere (please indicate)	( ) None Date: Rt _____ Lt _____ Both _____ Rt _____ Lt _____ Both _____ Rt _____ Lt _____ Both _____ Rt _____ Lt _____ Both _____ Rt _____ Lt _____ Both _____ Rt _____ Lt _____ Both _____ No <input type="checkbox"/> Yes <input type="checkbox"/> Date: _____
<b>To the best of my knowledge, I am not currently pregnant</b>	
<b>Signature:</b> _____	<b>Date:</b> _____