

PATIENT NAME: _____ **DATE OF BIRTH:** _____

Where/When was your last mammogram? _____

Are you having problems with your breasts? **Yes** **No**
If yes, explain _____

Do you have breast implants? **Yes** **No**

Have you ever had any breast surgeries, biopsies or aspirations? **Yes** **No**
If yes, explain _____

Do you have a history of breast cancer? **Yes** **No**
If yes, which breast? _____

Have you ever had breast radiation or chemotherapy? **Yes** **No**
If yes, explain _____

Is there a history of breast cancer in your family? **Yes** **No**
If yes, who and what age were they diagnosed? _____

Any possibility of pregnancy? **Yes** **No** **Don't know** Are you breast feeding? **Yes** **No**

First date of last menstrual period? _____

Number of full term pregnancies? _____ Age at menopause? _____ Age at first period? _____

Hysterectomy? **Yes** **No** If yes, what age? _____

Taken birth control pills? **Yes** **No** How long? _____

Taken hormone replacements? **Yes** **No** How long? _____

10 pound weight change within last year? **Yes** **No**

Signing below indicates that you have read and understand this form and have completed it to the best of your ability.

Patient or Legal Representative Signature _____

Technologist Signature _____ Date _____