Heartland IMAGING

Mammography History Form

PATIENT INFORMATION

Fall Precaution ☐ YES ☐ NO

Last Name	First Name/Middle Initial	DOB	Age	Race
		/ /		

Is today's evaluation your first mammogram: ☐ YES ☐ NO

If not, year and location of your last mammogram____

Year of your last breast exam performed by a healthcare professional_______________________________________

CURRENT SYMPTOMS

	Which breast?	Duration?
Lump:	L / R	____________
Nipple inversion:	L / R	____________
Skin retraction:	L / R	____________
Tenderness:	L / R	____________
Discharge:	L / R	____________

Color of discharge: ______________________________

Other symptoms: ________________________________

____

BREAST CANCER HISTORY

Have you ever had breast cancer? ☐ YES ☐ NO

If yes, please answer the following:

Which breast? ☐ RIGHT ☐ LEFT

Year of diagnosis: ________________________

Type of surgery: ☐ **Lumpectomy** ☐ **Mastectomy**

Did you have chemotherapy? ☐ YES ☐ NO

Did you have radiation? ☐ YES ☐ NO

Name of surgeon: __________________________________

Name of medical oncologist: ______________________

Name of radiation oncologist:

HORMONE HISTORY

Date of your last menstrual period: ____________________

Have you ever taken hormones?: ☐ **YES** ☐ **NO**

If yes, list type (birth control, hormone replacement, etc) and dates of use: ______________________________________

____

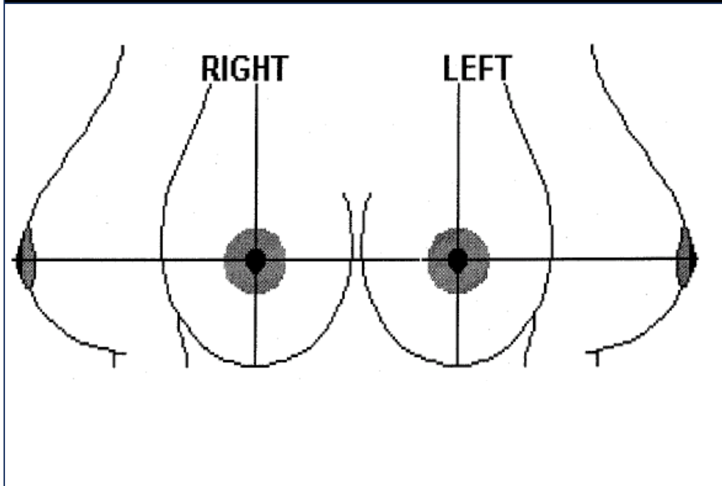
Breast fed in the last six months? ☐ **YES** ☐ **NO**

Currently breast feeding? ☐ **YES** ☐ **NO**

Weight changed more than 15 lbs since your last mammogram? ☐ **YES** ☐ **NO**

If yes, please specify:______________________________

FOR TECHNOLOGIST USE ONLY



BREAST SURGICAL & BIOPSY HISTORY

Breast reduction: ☐ **YES** ☐ **NO** **if yes, year** _______

Implants: ☐ **YES** ☐ **NO** **if yes, year** _______

Please list any previous benign breast surgeries or biopsies, including which breast and the approximate year:

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TECHNOLOGIST COMMENTS

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TECHNOLOGIST SIGNATURE, DATE & TIME