Community HOSPITAL

RADIOLOGY DEPARTMENT

MAMMOGRAPHY FEMALE PATIENT HISTORY

Revision Date: 8/21/18

Exam Date:_____
Status:
DOB: Age:

Name:_____

Ref Phys:
Att Phys:
Prim Care Phys:
Register/Admit Date:

(Place Pre-Printed Patient Data Label Here)

1. Are you having any new/current breast problems? If yes, what type: (check all that apply) Yes No
   ☐ **pain** ☐ **lump** ☐ **discharge** ☐ **other:** _____

   If discharge, what color? _____ For how long? _____

2. **Preferred name to be called:** _____ Physician name: _____
3. Previous Last name _____
4. Have you had a previous mammogram? Yes No

   When? _____ Facility where you had mammogram_____
5. Have you ever had breast surgery/biopsy? Yes No
   Date _____ Which breast(s) _____ ☐ Benign ☐ Malignant
6. Do you currently have breast implants? When was your surgery_____ Yes No
7. Have you been diagnosed with cancer? Yes No

   Type of cancer_____ Age of Diagnosis_____
8. Has anyone in your family been diagnosed with cancer? Yes No

Relationship	Cancer Type	Age of Diagnosis

Date_____ Time_____Patient Signature_____Tech _____