Community HOSPITAL

RADIOLOGY DEPARTMENT

MALE MAMMOGRAPHY PATIENT HISTORY

Revised: 4/25/16

Exam Date:_____
Status:
DOB: Age:

Name:_____

Ref Phys:
Att Phys:
Prim Care Phys:
Register/Admit Date:
(Place Pre-Printed Patient Data Label Here)

(Please fill in your name and answer questions 1 through 7)

Patient Name: _____

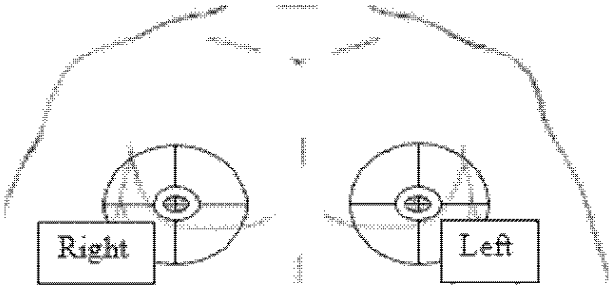
1. Physicians Name: _____
2. Are you having any current breast problems?..... Yes No
   If yes, what type:(Circle one).. pain..... lump… discharge….. Other: _____
3. Date of last physical breast exam by your doctor:_____
4. Have you had a previous mammogram?..... Yes No
   When? _____
   Where? _____
5. Have you ever had Breast Surgery?..... Yes No
   When and what area?_____
6. Have you been told you have cancer?..... Yes No
   What area? _____
   Age it was diagnosed: _____
7. Do you have any family history of breast cancer?..... Yes No
   Relationship: _____
   Their age at diagnosis:_____
   If mother or sister was it before menopause?..... Yes No

TO BE FILLED OUT BY MAMMOGRAPHY TECHNOLOGIST

CHECK: Breast Surface (including medial, inferior) Nipples, inverted? _____

Discharge?...Yes No How long?_____

Barriers to understanding…..... YES NO If there were any barriers to understanding this document what action was taken (e.g., interpreter used,etc.):_____



_____ _____ _____

Date Time Tech Signature

NAME: **DOB:**