MAMMOGRAPHY WORKSHEET **Women's Care Specialist**

NAME_____ MRN_____Date_____

AGE_____ DATE OF BIRTH_____/_____/_____ PHYSICIAN _____

BREAST HISTORY:
Previous Mammogram: Y / N Year: _____ Facility /City/State: _____

Personal History of Breast Cancer: Y / N Type: _____

Family Members with Breast Cancer: (specify Mother, Sister, Daughter, and age): _____

BREAST SYMPTOMS: Y / N

			How Long
Lumps/Thickness	Right	Left	_____
Nipple Discharge	Right	Left	_____
Nipple Retraction	Right	Left	_____
Pain/Tenderness	Right	Left	_____
Moles/Scars/Bruises	Right	Left	_____
Other_____	Right	Left	_____

Are You Pregnant? Y / N

Date last menstrual cycle started_____

If on supplemental hormones, date started_____

What was the age of first menstrual cycle started? _____

How old were you at the birth of your first child? _____

BREAST SURGERY:

			Date
Breast Reduction	Right	Left	_____
Breast Implants	Right	Left	_____
Cyst Aspiration	Right	Left	_____
Benign Biopsy-Core	Right	Left	_____
Benign Biopsy-Excisional	Right	Left	_____

Cancer Treatment

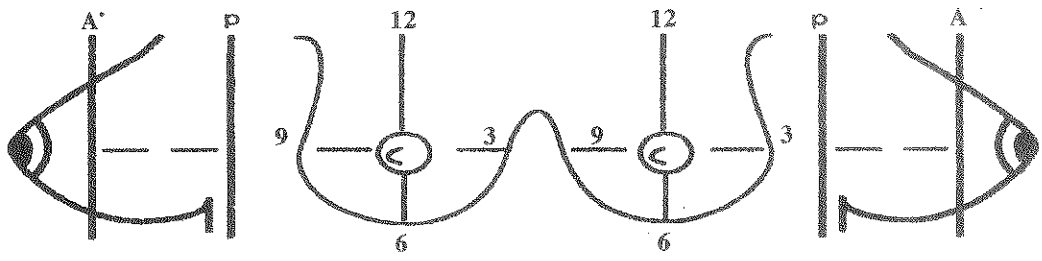
Mastectomy	Right	Left	_____
Radiation	Right	Left	_____
Lumpectomy	Right	Left	_____

PATIENT SIGNATURE _____DATE_____

BELOW THIS LINE FOR TECHNOLOGIST USE

EXAM TYPE (circle one): SCREENING / DIAGNOSTIC **(circle one): *SYMPTOMATIC / CALL BACK / 6 MONTH F/U***

Was ultrasound performed? Y / N If yes, additional history sheet must be completed.



O **Mole**

Δ **Palpable**

-/-/-/- **Scar**

Right **Left**

If a unilateral exam, cross out the breast that is not imaged.

Technologist's initials: _____ **Notes:** _____

_____

_____

_____

_____

If examination is for palpable lesion, mark location of palpable abnormality with an "Δ" in two views on diagram.