Mammography History Form

COUNTY HOSPITAL

to be filled out by the patient

Note: If there is deodorant or powder on your breast or on your underarms, please wash it off before you have the mammogram. Ask the technologist for help if you need it.

Name: _____ Date of Birth: _____ Age: _____

Address: _____ Last 4 digits of SSN: _____

Referring M.D.: _____ Today's Date: _____

1. Have you had a mammogram before? NO_____ YES_____
   Where and When? _____
2. Is this mammogram routine? YES_____ NO_____
   If no, why? _____
   (? lump, discharge, retraction, thickening, pain, follow-up for calcifications, follow-up for densities)
3. Have YOU or anyone in YOUR FAMILY had breast cancer? NO_____ YES_____
   IF YES: AT WHAT AGE WAS IT FOUND?
   _____ Myself _____
   _____ Mother _____
   _____ Sister _____
   _____ Daugher _____
   _____ Other _____
4. Have you had a child? NO_____ YES_____
   YOUR AGE WHEN YOUR FIRST CHILD WAS BORN: _____
5. Do you, or have you used hormones? (Estrogen, Premarin, Provera, Tamoxifen)
   NO_____ YES_____
   Which type? _____
   How long? _____
   Still using? _____ Stopped when? _____
6. Have you breast-fed within the past 3 months? NO_____ YES_____
7. Have you had a weight change of more than 10 pounds in the past year? NO_____ YES_____
8. Have you ever had trauma to your breast to cause black and blue marks? NO_____ YES_____

I hereby authorize Caldwell County Hospital to obtain or release mammogram films and collect medical information from my physician, clinic or hospital concerning breast disease. I understand that such information will be kept strictly confidential and will not be used for purposes other than scientific analysis and reporting. Furthermore, I understand that any follow-up care I may require is my responsibility.

_____ _____

Signature Date

S D R L U ***to be filled out by the technologist***

Pregnant? _____

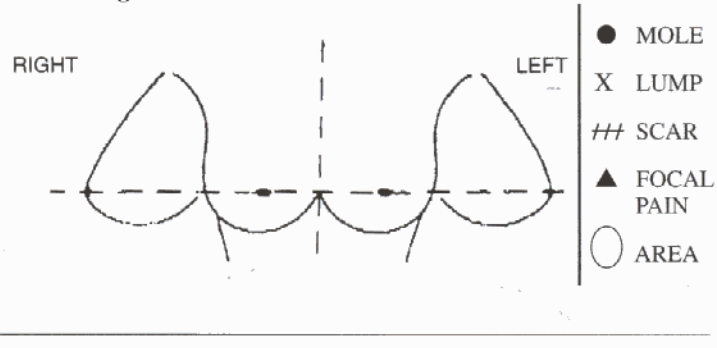
Check: Breast surface (including medial, inferior)

Nipples: inverted? discharge? How long? _____

Breast size discrepancy: Which? _____

Last clinical breast palpation: When? _____

History of prior breast surgery or aspiration (reason, place, date):



_____

Reasons for added view: _____

Comments: _____

Tech Signature: _____ Radiologist: _____

Unit was disinfected per protocol? YES_____ NO_____