DRCTC Mammography Patient History

Patient Name: ______________________ Doctor's Name: ________________

Radiology # ________________ D.O.B. _____/_____/_____ Age: ____________

Date: ______________ Technologist: ______________________________

Previous Mammograms? ______ When? _________ Films Sent For? ____________

Location: ____

Previous Breast Surgery? Yes No

____Biopsy _____Right ____Left When?_________ Results_______________

____Reduction _____Right ____Left When?_________

____Implants _____Right ____Left When?_________

____Mastectomy _____Right ____Left When?_________ Chemotherapy? __________

____Lumpectomy _____Right ____Left When?_________ Radiation Therapy? _______

Number of Pregnancies _____________ Hormone History ________________

Age at First Period _______Last Menstrual Cycle: ________Age at Menopause ________

Hysterectomy? ____________________ Oophorectomy? ____________________

Family History of Breast Cancer? Yes No

Mother _______ Sister _______ Daughter _______ Aunt _______ Other ___________

Any Complaints? ____

______ Nipple Discharge? Color: _____________ Duration: ________________

______ Lump? ______ Right ______ Left

______ Pain? ______ Right ______ Left

Any Scars, Marks, or Moles? _____________________________________

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