

MAMMOGRAPHY WORKSHEET

NAME _____ MRN _____

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

BREAST SURGERY:

		How Long				Date	
Lumps/Thickness	Right	Left	_____	Breast Reduction	Right	Left	_____
Nipple Discharge	Right	Left	_____	Breast Implants	Right	Left	_____
Nipple Retraction	Right	Left	_____	Cyst Aspiration	Right	Left	_____
Pain/Tenderness	Right	Left	_____	Benign Biopsy-Core	Right	Left	_____
Moles/Scars/Bruises	Right	Left	_____	Benign Biopsy-Excisional	Right	Left	_____
Other _____	Right	Left	_____				

Cancer Treatment

Are You Pregnant? Y / N	Mastectomy	Right	Left	_____
Date last menstrual cycle started _____	Radiation	Right	Left	_____
If on supplemental hormones, date started _____	Lumpectomy	Right	Left	_____

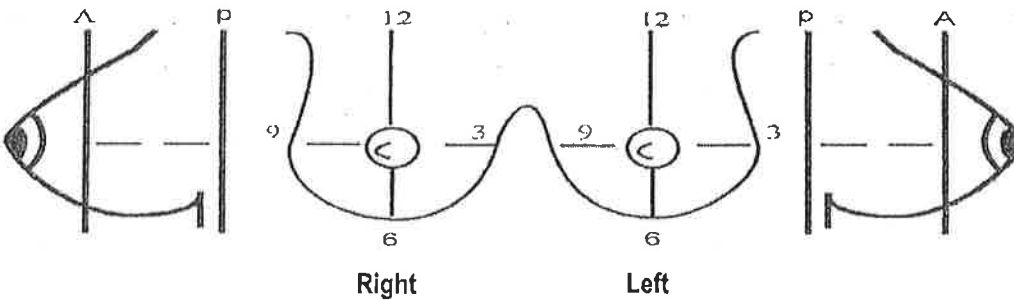
PATIENT SIGNATURE _____ DATE _____

-----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.



Technologist's Initials: _____ Notes: _____

If examination is for palpable lesion, mark location of palpable abnormality with an "Δ" in two views on diagram.
 If a unilateral exam, cross out the breast that is not imaged.