**Date**_____**MRN**_____**PID**_____

**Name (Last)**_____**(First)**_____**(M)**____

**DOB**_____**Sex:**_____**M**_____**F**

**Primary Care Provider Information:**

**Name:**_____**Fax:**_____

**Why are you having this mammogram?** (Mark one)

____Screening
____Lump or Thickening
____Skin Changes or Retraction
____Pain (Chronic or New)
____3 or 6 Months Follow-Up
____Nipple Discharge (please note color of discharges_____)
____Breast Implant problem
____Other (please specify_____)

**Have you ever had a mammogram?** If yes, when:_____where: _____

**Have you had any breast surgery or treatment?** (Mark one) **YES NO**

| Procedures: | Where: | When: | Results: |
|---|---|---|---|
| ____Cyst Aspiration | right left | _____ | _____ |
| ____Biopsies | right left | _____ | _____ |
| ____Lumpectomy | right left | _____ | _____ |
| ____Mastectomy | right left | _____ | _____ |
| ____Radiation | right left | _____ | |
| ____Reduction | right left | _____ | |
| ____Implants | right left | _____ | _saline_silicon_pre-pectoral_retro-pectoral |

**Have you or anyone in your family been diagnosed with breast cancer?**(circle one) **YES NO**

___Myself ___Mother ___Sister ___Daughter ___Grandmother ___Aunt

At What Age? _____ _____ _____ _____ _____ _____

**Do you, or have you used hormones replacement therapy?** **YES NO**

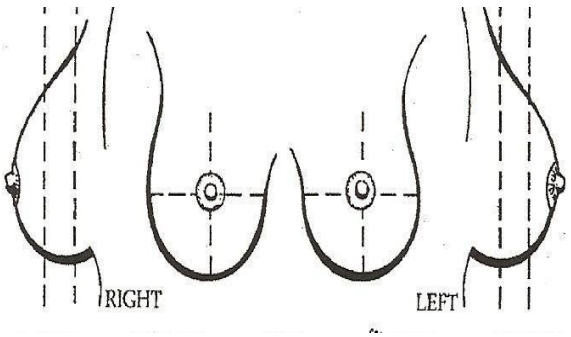
Age of Hysterectomy_____Age of Menopause_____Date of last menstrual period _____

**Are you pregnant?**_____**Have you ever been pregnant?**_____**If yes, how many children?** _____

**Have you had a weight (increase/decrease) of ten pounds in the last year?** **YES NO**

*Mammography is an x-ray examination of the breast used primarily to detect cancer. Although mammography is the single best method of detecting breast cancer, it cannot find all breast cancers. Combined with monthly breast self-examinations and yearly clinical exams by your doctor, you can achieve good breast care. In order to obtain the best mammogram, it is essential that the breast be firmly compressed for a few seconds during the examination, which may cause some slight discomfort. A radiologist will interpret your films and the results will be sent to you and your doctor. Our technologists will be glad to provide you with additional information on mammography and breast self-examinations.*

**Patient Signature:**_____**Date** _____




**Technologist:**_____**Date:** _____

**Have you received the Flu vaccine?** (circle one) **Yes No If Yes, Date**_____

**Have you received the Covid-19 vaccine?** (circle one) **Yes No If yes, First dose date**_____**Second dose Date**_____ **Booster Shot Date**_____

*Revised 11/15/2021*