Mammography Intake Form

Referring physician: ______________________________

DIAGNOSTIC CENTER FOR women

PATIENT INFORMATION

Patient's name	Date of birth	Age	Sex ◯ M ◯ F	Email address

Address	City, State, Zipcode	Home #	Work #

PERSONAL HISTORY

Is this your first mammogram ever? ◯ Yes ◯ No

If no, when and where was the previous mammogram(s) done?

____

Do you have breast implants? ◯ Yes ◯ No

If yes: ☐ Silicone ☐ Saline ☐ Combination

Have you had a Breast Reduction? ◯ Yes ◯ No

Have you had a Breast Lift? ◯ Yes ◯ No

Have you had a breast biopsy? ◯ Yes ◯ No

If yes: ☐ Right ☐ Left ☐ Both

If yes, did biopsy show?

Atypical Hyperplasia ◯ Yes ◯ No

Lobular Carcinoma In situ (LCIS) ◯ Yes ◯ No

Have you had an excisional biopsy? ◯ Yes ◯ No

If yes:_____Right _____Left _____Both

Have you ever been diagnosed with cancer? ◯ Yes ◯ No

If yes, what type(s) and age at diagnosis:

☐ Breast________ ☐ Ovarian________ ☐ Uterine________

☐ Colorectal________ ☐ Stomach________ ☐ Pancreatic________

☐ Melanoma________ ☐ Prostate________ ☐ Other ____________

Have you had a Mastectomy? ☐ Right ☐ Left ☐ Both

Date: ___________

Have you had a Lumpectomy? ☐ Right ☐ Left ☐ Both

Date: ___________

Have you had Radiation therapy? ☐ Right ☐ Left ☐ Both

Date: ___________

Have you had any Chemotherapy? ◯ Yes ◯ No

Date: ___________

Age when Menstruation began: ☐ 7-11 ☐ 12-13 ☐ >14

Age when Menstruation stopped? Age:______________

Date of last Menstrual period? Date: ______________

Have you ever been pregnant? ◯ Yes ◯ No

How old were you when you delivered your first child? Age: ___________

ETHNIC ORIGIN

☐ White ☐ Black ☐ American Indian

☐ Asian ☐ Pacific Islander ☐ Caribbean Island

☐ **Ashkenazi Jewish** ☐ Hispanic ☐ Other ______________

INDICATED PROBLEMS

Do you currently have?

☐ Lump you can feel ☐ Right ☐ Left

☐ Nipple abnormality/discharge ☐ Right ☐ Left

☐ Pain ☐ Right ☐ Left

☐ None

If yes, to any of these, please explain:

____

____

____

FAMILY HISTORY

Are you adopted? ◯ Yes ◯ No

Have any of your family members been diagnosed with cancer? ◯ Yes ◯ No

Enter (1) who and (2) age at diagnosis:

☐ Breast________________ ☐ Ovarian________________

☐ Uterine________________ ☐ Colorectal________________

☐ Stomach________________ ☐ Pancreatic________________

☐ Melanoma________________ ☐ Prostate________________

☐ Other ______________________________________

Has someone in your family tested positive for a mutation that increases their risk for cancer? ◯ Yes ◯ No

If yes, who and which gene (if you know)?

____

Do you want to learn your risk for the most common hereditary cancers? ◯ Yes ◯ No

SIGNATURES

To the best of my knowledge I am not currently pregnant. Signature: ______________________________

Patient's signature:______________________________Date: ______________