Diagnostic Center of Miami
TopLine MD Alliance

Mammography Intake Form

Ordering Physician: _____ Primary Care Physician: _____

Patient's name (First and Last)	Date of birth	Age	Sex ☐M☐ F	Email address
Address	City, State, Zip code		Phone #	

PERSONAL HISTORY

Is this your first mammogram? ☐Yes ☐ No

When and where were your previous mammograms done?

_____

INDICATED PROBLEMS

Do you have any **new** breast symptoms/complaints?

☐None
☐Nipple abnormality/discharge ☐Right ☐Left
☐Pain ☐Right ☐Left
☐Lump you can feel ☐Right ☐Left

Please explain:

_____
_____
_____

BREAST RELATED HISTORY

Do you have breast implants? ☐ Yes ☐ No

If yes: ☐ Silicone ☐ Saline ☐ Combination

Have you had a breast reduction or lift? ☐ Yes ☐ No

Have you had a needle biopsy? ☐ Yes ☐ No

If yes: ☐ Right ☐ Left ☐ Both

If yes, what did the biopsy show?

☐ Unknown ☐ Benign _____
☐ Atypical Hyperplasia ☐ Lobular Carcinoma in Situ (LCIS)
☐ Cancer _____

Have you had a surgical/excisional biopsy? ☐ Yes ☐ No

If yes: ☐ Right ☐ Left ☐ Both

Have you ever been diagnosed with **breast cancer**? ☐ Yes ☐ No

Have you had:

A **mastectomy?** ☐Right ☐Left ☐Both Date: _____

A **lumpectomy?** ☐Right ☐Left ☐Both Date: _____

Radiation? ☐Right ☐Left ☐Both Date: _____

Chemotherapy? ☐Yes ☐No Date: _____

ADDITIONAL HISTORY

Age when menstruation began: _____

Have you had a hysterectomy? ☐ Yes, age: _____ ☐ No

Age when menstruation stopped? _____

Date of last menstrual period? _____

Are you currently taking hormones (i.e. birth control, hormone replacement therapy)? ☐ Yes ☐ No

Have you ever been pregnant? ☐ Yes ☐ No

How old were you when you delivered your first child? _____

Have you ever had fertility treatment? ☐ Yes ☐ No

If yes, what type and when? _____

Have you been diagnosed with any other type of cancer? ☐ Yes ☐ No

If yes, what type(s) and how old were you at diagnosis?

☐Ovarian _____ ☐Uterine _____ ☐Colorectal _____
☐Stomach_____ ☐Pancreatic_____ ☐Melanoma_____
☐Other_____

RACE AND ETHNICITY

☐White ☐Asian ☐American Indian/Alaskan
☐Hispanic/Latin ☐Black/African ☐Hawaiian/Pacific Islander
☐Ashkenazi Jewish ☐Other _____

FAMILY HISTORY

Has someone in your family tested positive for a mutation that increases their risk for cancer (i.e. BRCA, etc.)? ☐ Yes ☐ No

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

Have any of your blood related family members been diagnosed with cancer? ☐ Yes ☐ No

Enter **who and age** at diagnosis:

☐Breast_____ ☐Ovarian_____
☐Uterine_____ ☐Colorectal_____
☐Stomach_____ ☐Pancreatic_____
☐Melanoma_____ ☐Prostate_____
☐Other_____

Are you adopted? ☐ Yes ☐ No

Patient's signature: _____ Date_____