

Mammography Worksheet SIRA Imaging Center, L.L.C.

Sex Female Male

Last Name:		First Name:		MI	DOB	Age
MR #	SSN	Home phone		Work phone X		
Address		City		State	Zip	
Physician						

► Is this your first mammogram? Yes No

Where was your last mammogram? _____ When? _____

► Are you having any new problems with your breasts? YES NO

If yes what? Lump (new or enlarging) Right Left

Discharge from the nipple Right Left

Skin changes Right Left *Please describe* _____

Other: Right Left *Please describe* _____

Have you had any of the following?

- | | | |
|--|------------------|-------|
| <input type="checkbox"/> Breast cancer gene | Age of Diagnosis | _____ |
| <input type="checkbox"/> History of breast cancer | | _____ |
| <input type="checkbox"/> History of ovarian cancer | | _____ |
| <input type="checkbox"/> History of endometrial cancer | | _____ |
| <input type="checkbox"/> History of colon cancer | | _____ |
| <input type="checkbox"/> Other Cancer: _____ | | _____ |

Has anyone in your family had a history of breast cancer?

Relative	at Age	Mother's side	Father's side
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

Are you Pregnant? YES NO Number of live births _____ First full-term pregnancy at age _____
 Menopause at age _____ Hysterectomy at age _____

Do you have breast implants? YES NO Right Date _____ Silicone Gel Saline
 Left Date _____ Silicone Gel Saline

Have you had any significant weight change? If yes, please indicate (+) or (-) _____ lbs

► Are there any changes in your breast surgical and treatment history below?

Please mark any changes from above in this section: Include date, type, and result

- Have you had a:
- Reduction Right Left When? _____
 - Biopsy Right Left When? _____ Benign Cancer found
 - Lumpectomy for breast cancer Right Left When? _____
 - Mastectomy for breast cancer Right Left When? _____
 - Radiation When? _____
 - Chemotherapy When? _____

Are you currently using any of the following? (Check all that apply.)

Hormone History	Currently Using	Age at First Use	Age at Last Use
Hormonal contraceptives	<input type="checkbox"/>	_____	_____
Estrogen	<input type="checkbox"/>	_____	_____
Progesterone	<input type="checkbox"/>	_____	_____

Currently Using	Age at First Use	Age at Last Use
<input type="checkbox"/> Tamoxifen?	_____	_____
<input type="checkbox"/> Femara	_____	_____
<input type="checkbox"/> Arimidex	_____	_____
<input type="checkbox"/> Aromasin	_____	_____

PATIENT SIGNATURE _____

DATE: ___/___/___