

MedWise PC

An Affiliate of Radiology Ltd.

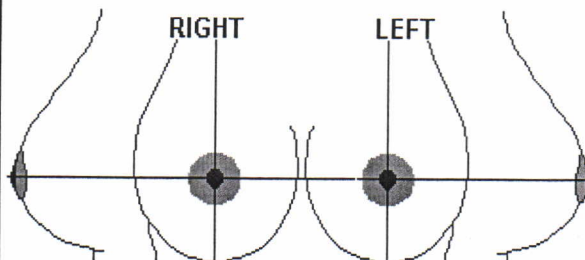
MAMMOGRAM PATIENT HISTORY

Name: _____ Date: _____
 DOB: _____ AGE: _____ Sex: _____ MRN: _____ Acc#: _____
 Requesting: _____ Phone: _____ Fax: _____ Backline: _____
 Other Physician _____ Exam Code: _____

1. Do you have a lump or any other breast abnormality? No Yes _____
2. Have you ever had a mammogram? No Yes If yes, where and when?
3. Have you ever had breast surgery? No Yes If yes: Implants Reduction Biopsy
4. Have you ever been diagnosed with cancer? No Yes If yes, location / type: _____
5. Any family history of breast or ovarian cancer? No Yes If yes, check all that apply and the age they were diagnosed
 Mother Age:____ Daughter(s) Age: ____ Maternal Aunt(s) Age : ____ Maternal Grandmother Age: ____
 Sister(s) Age:____ First Cousins Age: ____ Paternal Aunt(s) Age: ____ Paternal Grandmother Age: ____
6. At what age did your first menstrual cycle begin? _____
7. Any male family members with history of breast cancer? No Yes
8. Are you taking hormones (Estrogen, Contraceptives, Tamox)? No Yes _____
9. Is there any possibility you could be pregnant? No Yes

Patient Signature _____ Date _____

BIOPSY	Right	Left	Date	Result
Needle				
Ultrasound				
Surgical				
Lumpectomy	Right	Left	Date	
Mastectomy	Right	Left	Date	
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Radiation Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No		Date Ended	



Tech Signature: _____ # of Images: _____ Room #: _____ Prior Mammograms: _____