

DOCTORS GROOVER  
CHRISTIE & MERRITT  
RADIOLOGISTS

Mammogram Patient History

Last name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Previous last names \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_

Please answer ALL of the following questions to assure you receive the appropriate mammographic services. If you have any questions regarding this form, ask the technologist for assistance.

Date and location of your last mammogram \_\_\_\_\_

Bra cup size (check one of the following): \_\_\_\_\_ Smaller than C cup \_\_\_\_\_ C cup or larger

- A. Reason for today's visit
- routine mammogram (no problem) Skip to Section B
  - evaluation of a problem
    - new or enlarging palpable lump            yes   no   L/R
    - focal breast pain                                yes   no   L/R
    - nipple discharge                                yes   no   L/R Color \_\_\_\_\_
    - nipple inversion                                yes   no   L/R How Long? \_\_\_\_\_
    - other \_\_\_\_\_
- Is this a follow-up to an abnormal mammogram?    yes   no

- B. Breast surgery history:
- Prior benign surgical biopsy                    yes   no   L/R   Date/Age \_\_\_\_\_
  - Prior benign core needle biopsy                yes   no   L/R   Date/Age \_\_\_\_\_
  - Prior cyst aspirations                            yes   no   L/R   Date/Age \_\_\_\_\_
  - Lumpectomy for breast cancer                    yes   no   L/R   Date/Age \_\_\_\_\_
  - Radiation for breast cancer                    yes   no   L/R   Date/Age \_\_\_\_\_
  - Mastectomy                                        yes   no   Date/Age \_\_\_\_\_
  - Reduction surgery                                yes   no   Date/Age \_\_\_\_\_
  - Implants: Saline / Silicone (circle one)        yes   no   History of Rupture?    yes   no

C. Family history of breast cancer: yes   no   Relationship \_\_\_\_\_ Age at diagnosis \_\_\_\_\_

When was the last time your doctor did a breast physical exam? \_\_\_\_\_

Since your last mammogram, have you  started  stopped  changed the dose or type of hormone therapy? Dose \_\_\_\_\_ Type \_\_\_\_\_

If you are still menstruating, please inform the technologist if you think you might be pregnant.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

NOTE: A diagnostic mammogram will take a minimum of 1.5 hours.

For technologist's use only:  
Comparison Films:  
CAD: Yes / No

Technologist: \_\_\_\_\_  
Physician: \_\_\_\_\_

