MAMMOGRAPHY

Worksheet

CHEYENNE RADIOLOGY

CHEYENNE WOMEN'S IMAGING PAVILION

Today's date: _____ Jacket #: _____

PATIENT INFORMATION

Patient's last name: _____ First: _____ Middle: _____

Birth Date: _____Age: _____ Sex: ☐ M ☐ F Height:_____ Weight:_____

Social Security no.: _____ Home Phone:_____

Street address: _____ P.O. Box:_____

City: _____State: _____ Zip Code:_____

Do you Smoke? ☐ Yes ☐ No

PERSONAL RISK FACTORS

☐ Breast Cancer Gene Age: _____

☐ History of breast cancer Age: _____

☐ History of endometrial cancer Age: _____

☐ History of ovarian cancer Age: _____

☐ History of high-risk lesion Age: _____

☐ History of colon cancer Age: _____

FAMILY BREAST CANCER

Relative: At Age:

_____

_____

_____

_____

_____

GYNECOLOGICAL HISTORY

Are you pregnant ☐ Yes ☐ No

Have you breast fed in the last 6 months ☐ Yes ☐ No

First Menstrual period at age: _____

First full-term pregnancy at age: _____

Number of live births: _____

Hysterectomy at age:_____

Menopause at age: _____

Right Ovary removed at age: _____

Left Ovary removed at age:_____

Check if no children_____

Last Menstrual Period: _____

BREAST IMPLANTS

☐ **RIGHT:** ☐ Silicone ☐ Saline ☐ Combination ☐ Pre-pectoral ☐ Retro-pectoral Date: _____

☐ **LEFT:** ☐ Silicone ☐ Saline ☐ Combination ☐ Pre-pectoral ☐ Retro-pectoral Date: _____

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BREAST SURGICAL AND TREATMENT HISTORY

Include date, type and result:

Cyst Aspiration ☐ R ☐ L ☐ B YR:_____

Needle Biopsy ☐ R ☐ L ☐ B YR:_____

If Yes, Outcome: ☐ Benign ☐ Cancerous

Lumpectomy (cancerous): ☐ R ☐ L ☐ B YR:_____

Excisional biopsy (non-cancerous): ☐ R ☐ L ☐ B YR:_____

Mastectomy : ☐ R ☐ L ☐ B YR:_____

Radiation: ☐ R ☐ L ☐ B YR:_____

Reduction: ☐ R ☐ L ☐ B YR:_____

Stereotactic Biopsies: ☐ R ☐ L ☐ B YR:_____

HORMONE HISTORY

Have you in the past or are you currently taking hormones? ☐ Yes ☐ No

If yes, please describe below: _____

_____

If no longer using hormones please specify below, dates used.

Hormones	Currently Using	Age at First Use	Age at Last Use	Duration of Use
Birth Control				Years: __ Months: ____
Estrogen				Years: __ Months: ____
Progesterone				Years: __ Months: ____
Tamoxifen				Years: __ Months: ____
Unspecified Hormones				Years: __ Months: ____

CURRENT COMPLAINTS/SYMPTOMS ☐ Yes ☐ No

If Yes, Please describe: (Lumps, Pain, discharge from nipple or other) _____

_____

☐ First Mammogram Time since last mammogram: Years: ____ Months: ____ ☐ <1month

Where are your previous films stored? _____

The above information is correct to the best of my knowledge.

Patient's Signature: _____ **Date:** _____