MAMMOGRAPHY WORKSHEET North Jefferson Imaging

NAME____ MRN______________________

AGE________ DATE OF BIRTH_____/______/______ PHYSICIAN ___________________________________

BREAST HISTORY:

Previous Mammogram: Y / N Year: _____________ Facility/City/State: _________________________________

Personal History of Breast Cancer: Y / N Type: ____

Family Members with Breast Cancer: (specify Mother, Sister, Daughter, and age): ______________________________

BREAST SYMPTOMS: Y / N

			How Long
Lumps/Thickness	Right	Left	______
Nipple Discharge	Right	Left	______
Nipple Retraction	Right	Left	______
Pain/Tenderness	Right	Left	______
Moles/Scars/Bruises	Right	Left	______
Other______________	Right	Left	______

Are You Pregnant? Y / N

Date last menstrual cycle started_________________

If on supplemental hormones, date started__________

BREAST SURGERY:

			Date
Breast Reduction	Right	Left	_________
Breast Implants	Right	Left	_________
Cyst Aspiration	Right	Left	_________
Benign Biopsy-Core	Right	Left	_________
Benign Biopsy-Excisional	Right	Left	_________

Cancer Treatment

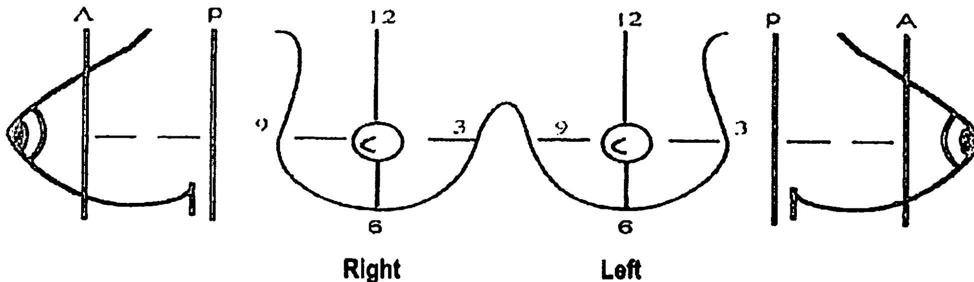
Mastectomy	Right	Left	_________
Radiation	Right	Left	_________
Lumpectomy	Right	Left	_________

PATIENT SIGNATURE ______________________________________ **DATE**_______________________

---***BELOW THIS LINE FOR TECHNOLOGIST USE***---

EXAM TYPE (circle one): SCREENING / DIAGNOSTIC **(circle one):** ***SYMPTOMATIC / CALL BACK / 6 MONTH F/U***

Was ultrasound performed? Y / N If yes, additional history sheet must be completed.



O Mole

Δ Palpable

-/-/-/- Scar

Technologist's Initials: _____________ **Notes:** ____

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If examination is for **palpable lesion**, mark location of palpable abnormality with an "**Δ**" **in two views** on diagram.

If a unilateral exam, cross out the breast that is not imaged.