St. Mary Medical Center
Mammography Patient Information
Please Answer All Questions YES or NO

Name:_____ Date of Birth: _____ Age:_____
Last First

Are you pregnant?..... YES☐ NO☐

Do you still have a period every month? ..... YES☐ NO☐

Date of last menstrual period_____.....Hysterectomy YES☐ NO☐

Have you breast fed within the last six months?..... YES☐ NO☐

Are you now taking birth control pills or any type of hormone?..... YES☐ NO☐

If yes, when did you start taking hormones? Month_____Year_____

Name of hormone_____

Have you ever had trauma to your breast to cause black and blue marks?..... YES☐ NO☐

Reason for Exam-Please check:

☐ Baseline (No previous Mammograms)

☐ Routine/Yearly Study_____
Approx. date of previous study and what facility was it performed?

☐ Follow-up_____
Approx. date of previous study and what facility was it performed?

Symptoms and History

Do you or your doctor feel a lump?_____ YES☐ NO☐
Which breast and for how long?

Do you have inverted nipples?_____ YES☐ NO☐
Which breast and for how long?

Do you have pain or tenderness? _____ YES☐ NO☐
Circle problem. Which breast and for how long?

Do you have nipple discharge?_____ YES☐ NO☐
Which breast and for how long?

Any other symptoms?_____ YES☐ NO☐
Please explain

Previous breast surgery?_____ YES☐ NO☐
Which breast and approximate date?

Have you had breast cancer? _____ YES☐ NO☐
Which breast and approximate date?

Radiation treatments to your breast(s)? _____ YES☐ NO☐
Which breast and approximate date?

Do you have breast implants?_____ YES☐ NO☐
Silicone or Saline?

Previous breast aspirations of cysts?_____ YES☐ NO☐
Which breast and approximate date?

Risk Factors

Do you have a history of any other cancer? If yes please explain…… YES☐ NO☐

_____

Your age at first pregnancy _____ Number of children_____

Did your natural mother, sisters or daughters have breast cancer?..... YES☐ NO☐

If yes, Pre or Post Menopausal _____ Age at diagnosis _____

St. Mary Medical Center requests your authorization to obtain your previous medical mammographic records and/or future outcome pertaining to this examination.

Patient Signature:_____ Date:_____

Technologist's Signature:_____