CHI St. Joseph Health

Mammography History Form

Note: If there is **deodorant** or **powder** on your breast or on your underarms, **please remove** it before you have your exam. Ask the technologist for help if you need it.

Name: _____ Date of Birth: _____ Age: _____

Today's Date: _____ Referring Physician: _____

1. Have you ever had a mammogram? ☐ No ☐ Yes
   If yes, where & when? _____
2. Do you have implants? ☐ No ☐ Yes
   If yes, please check all that apply: ☐ Saline ☐ Silicone Gel ☐ Double Lumen ☐ Augmentation ☐ Pre-pectoral ☐ Post-pectoral
3. Is this mammogram routine? ☐ No ☐ Yes
   If no, why? _____
   (lump, discharge, retraction, thickening, pain, follow-up for calcification)
4. Have you had breast cancer: ☐ No ☐ Yes
   If yes, at what age was it found? _____
5. Has anyone in your family ever had breast cancer? ☐ No ☐ Yes
   If yes, at what age was it found? _____
   5a. Relationship to family member who had breast cancer: ☐ Mother ☐ Sister ☐ Daughter ☐ Other
6. Do you have a family history of other cancer? ☐ No ☐ Yes
   If yes, specify: _____
7. Are you pregnant? ☐ No ☐ Yes
   Date of last menstrual period: _____ Age at first period: _____
8. Have you had a hysterectomy? ☐ No ☐ Yes
   If yes, were your ovaries removed? ☐ No ☐ Yes
9. Have you had a child? ☐ No ☐ Yes
   Your age when your 1st child was born? _____
   Number of pregnancies: _____ Number of births: _____
10. Do you, or have you used hormones (Estrogen, Premarin, Provera, Tamoxifen)? ☐ No ☐ Yes
    If yes, which type? _____
    How long? _____
    Still using? _____
    Stopped when? _____
11. Have you breast-fed within the past 3 months? ☐ No ☐ Yes
12. Have you had a weight change more than 10 pounds in the past year? ☐ No ☐ Yes
13. Have you ever had trauma to your breast serious enough to cause black & blue marks? ☐ No ☐ Yes
    If yes, when? _____

Signature: _____

To be filled out by the technologist

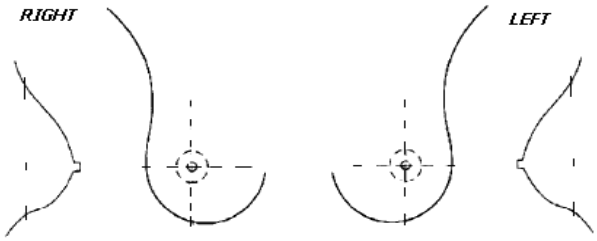
Pregnant? _____

Check: Breast surface (including medial, inferior)

Nipples: Inverted? Discharge? How long? _____

Breast size discrepancy? Which? _____

Last clinical breast palpation: _____



▲ FOCAL PAIN
× LUMP
/// SCAR
○ AREA

History of prior breast surgery or radiation (procedure, reason, place, date)

_____

Reason(s) for added view(s): _____