MARGARET MARY HEALTH

MAMMOGRAPHY SCREENING FORM

Patient's Name: _____

Date: _____

Address: _____

Phone: _____

Age: _____

Number of Children: _____

Age at First Pregnancy: _____

Previous Breast Surgery (including breast implants):

Left Breast _____ Right Breast _____

Mastectomy:

Left Breast _____ Right Breast _____

Personal History of Cancer? ❑ Yes ❑ No

If yes, circle those that apply:

Breast Uterine Ovarian Colon Other: _____

Hormone Medications:

Type of Hormone: _____ How long: _____

Previous Mammogram:

Location: _____ Year: _____

Age of first menstrual period: _____ Date of last menstrual period: _____

Have you had a hysterectomy? ❑ Yes ❑ No If so, when? _____

Do you have a family history of breast cancer? ❑ Yes ❑ No

If yes, check those that apply:

❑ Grandmother ❑ Mother ❑ Sister ❑ Aunt ❑ Daughter

Present breast complaints: _____

Nipple discharge? ❑ Yes ❑ No

Mass felt by your physician? ❑ Yes ❑ No

Ordering Physician: _____

Outside Appearance of the breast:

Skin growth: _____

Moles: _____

Scars: _____