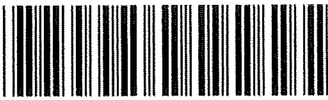


PAT0400

ST. VINCENT'S MAMMOGRAPHY HISTORY

Exam Date: ____________ Patient's Last Name: ________________ First: __________ MI: ____

Patient's Birth Date: __________ Age: _____ SSN: ____________ Patient's Physician: __________

Home Phone: (____) ____________ Office Phone: (____) ______________

Patient's Address: ______________________ City: ______________ State: ____ Zip: _____

Last Dr. Visit: ________ Last Mammogram Exam: _______ Where: _______ Under What Name? ________

Physician At That Time: ___________ Date Of Last Period: ___________ Last Breast Exam: ___________

Referring Physician's Address: ____________________ City: ____________ State: ____ Zip: _____

KNOWN PATIENT DATA:

- PLEASE SIGN BELOW TO DOCUMENT THAT YOU ARE NOT PREGNANT.
- I authorize obtaining or releasing my breast health records for comparison and follow up.
- I was offered the opportunity to view the Breast Self Examination Education video tape and I understand the importance of breast compression, annual exam by my physician and breast self examination because mammograms are approximately 90% accurate.

Patient's Signature: ______________________________ **Date:** ______________

KNOWN REFERRING DOCTOR:

Current Symptoms:

Lump:	☐ No	☐ Yes	☐ Right	☐ Left	☐ Both	☐ When Noticed? __________
Nipple Discharge:	☐ No	☐ Yes	☐ Right	☐ Left	☐ Both	☐ Color? __________

History:

Hysterectomy:	☐ No	☐ Yes	☐ When? ________	☐ Age or Year? __________
Hormones:	☐ No	☐ Yes	☐ When? ________	☐ Age or Year? __________

KNOWN MEDICAL HISTORY:

Family History of Breast Cancer – Check all those that apply:

☐ Personal History of Breast Cancer	☐ Age or Year? __________
☐ Aunt ☐ Grandmother ☐ Cousin	☐ Pre-menopausal ☐ Post-menopausal
☐ Mother ☐ Sister ☐ Daughter	☐ Pre-menopausal ☐ Post-menopausal

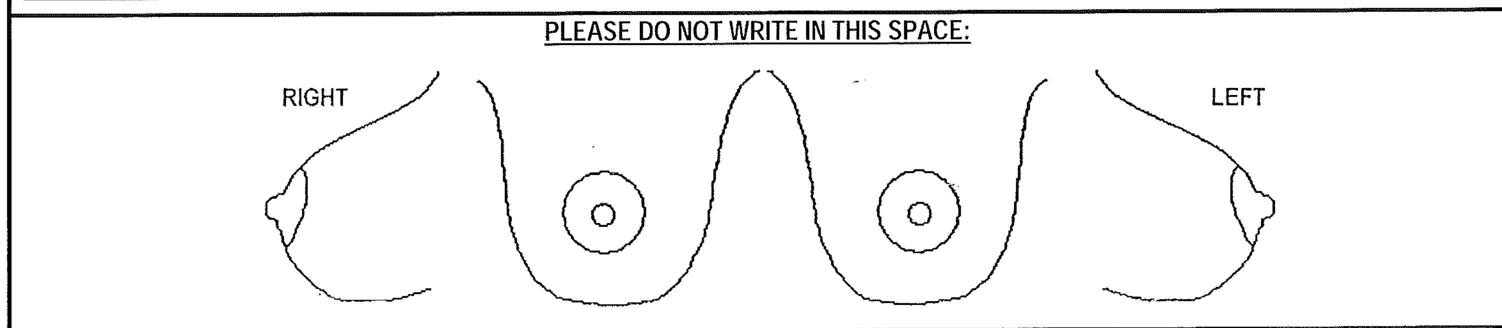
KNOWN RISK FACTORS:

Prior Breast Procedures: (Please indicate which Breast & Age or Year Done) L=Left, R=Right, B=Both

☐ Biopsy	☐ L ☐ R ☐ B	☐ When: _____	☐ Mastectomy	☐ L ☐ R ☐ B	☐ When: _____
☐ Implants	☐ L ☐ R ☐ B	☐ When: _____	☐ Lumpectomy	☐ L ☐ R ☐ B	☐ When: _____
☐ Reduction	☐ L ☐ R ☐ B	☐ When: _____	☐ Chemotherapy	☐ L ☐ R ☐ B	☐ When: _____
☐ Aspiration	☐ L ☐ R ☐ B	☐ When: _____	☐ Radiation	☐ L ☐ R ☐ B	☐ When: _____

PREVIOUS PROCEDURES:

PLEASE DO NOT WRITE IN THIS SPACE:



NOTES:

Tech. Initials: __________

Radiologist's Initials: __________