Breast Information

Name: ________________ **Date of birth:** ________ **Phone number:** ________________

Address: ________________________________ **Zip:** ____________

COVID Vaccination: Yes / No Date:____________ **Administration Site:** ☐ Right arm ☐ Left Arm ☐ Right thigh ☐ Left thigh

Date and location of last mammogram: ________________ **Physician:** ________________

BREAST SYMPTOMS

☐ No breast symptoms. This is my annual mammogram.
☐ New breast lump ☐ Right ☐ Left How long?________________
☐ Discharge ☐ Yes ☐ No
☐ Additional imaging after my regular mammogram.
☐ Short term follow-up. I am not having any new breast symptoms.
☐ Other breast symptom: ________________________________

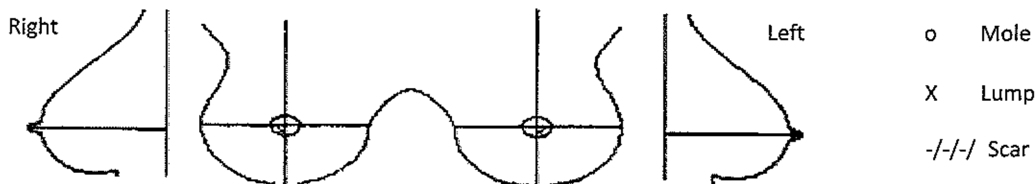
BREAST HISTORY			**DATE**
Breast Reduction: Breast	☐ Yes ☐ No	☐ Right ☐ Left	________
Implants:	☐ Yes ☐ No	☐ Right ☐ Left	________
Cyst Aspiration:	☐ Yes ☐ No	☐ Right ☐ Left	________
Needle Biopsy:	☐ Yes ☐ No	☐ Right ☐ Left	________
Surgical Biopsy:	☐ Yes ☐ No	☐ Right ☐ Left	________
Breast Cancer:	☐ Yes ☐ No	☐ Right ☐ Left	________
Mastectomy:	☐ Yes ☐ No	☐ Right ☐ Left	________
Lumpectomy:	☐ Yes ☐ No	☐ Right ☐ Left	________
Radiation:	☐ Yes ☐ No	☐ Right ☐ Left	________
Chemotherapy:	☐ Yes ☐ No	☐ Right ☐ Left	________
Are you pregnant?	☐ Yes ☐ No		

Have you had family members with breast cancer? (specify mother, sister, aunt):________________
Have you had any other type of cancer? ________________
Have you had positive genetic testing?________________

By signing this form, I acknowledge the above information to be true and complete. I authorize this institution to obtain or release my breast imaging records for comparison and follow up.

Patient Signature: ________________________ Date:____________

This section completed by the Mammography Technologist only



Technologist notes:________________________________

Date/time:____________ Image count:__________ Technologist Signature:________________