raleigh radiology

Mammography History

Patient:____ Today's Date: ____/______/________

Date of Birth: ___/_____/___ Age: ____ Phone #: ____________________

Self-Referral? ☐ Yes ☐ No Referring Doctor: ______________________________ Date of last visit: ____________

Primary Doctor, if different: ____ Date of last visit: ____________

Have you had a mammogram in the past? ☐ NO ☐ YES **Mammogram preference today?** ☐ 2D ☐ 3D

Facility: ____ Phone: (_______) _______-___________

Address: ____ Date of last mammogram: ___________

Family History

Have the following family members had Breast Cancer?				Age at diagnosis	Comments
Mother	☐ NO	☐ YES	☐ I don't know		
Sister	☐ NO	☐ YES	☐ I don't know		
Daughter	☐ NO	☐ YES	☐ I don't know		
Other	☐ NO	☐ YES	☐ I don't know		

Have you had breast cancer? ☐ NO ☐ YES → ☐ Right ☐ Left ☐ Both Age: ______

Have you had biopsy or surgery? ☐ NO ☐ YES → ☐ Right ☐ Left ☐ Both Age: ______

If you answered yes, please check all that apply:

	RT	LT	Both	Date
Cyst Aspiration	☐	☐	☐	_____/_______/______
Surgical Biopsy	☐	☐	☐	_____/_______/______
Needle Biopsy	☐	☐	☐	_____/_______/______
Mastectomy	☐	☐	☐	_____/_______/______
Lumpectomy	☐	☐	☐	_____/_______/______
Radiation Therapy	☐	☐	☐	_____/_______/______
Implants	☐	☐	☐	_____/_______/______
Chemotherapy	☐	☐	☐	_____/_______/______
Reconstruction	☐	☐	☐	_____/_______/______
Breast Reduction	☐	☐	☐	_____/_______/______
Other	☐	☐	☐	_____/_______/______

Are you having problems with your breasts at this time?

☐ NO ☐ YES If yes, how long? ___________

Is this the reason you made an appointment today? ______________

Check all that apply:	RT	LT	Both	
Pain	☐	☐	☐	
Discharge	☐	☐	☐	Color: _____________
Lump	☐	☐	☐	

Are you taking Hormone Replacement Therapy? ☐ NO ☐ YES

Are you taking Oral Contraceptives? ☐ NO ☐ YES

Date of last menstrual period: _______/_______/_______

LAST Covid Vaccine/Booster Date ________ Select Arm: RT LT NONE

Technologist Notes ONLY:

Body habitus_____

Medial fullness_____

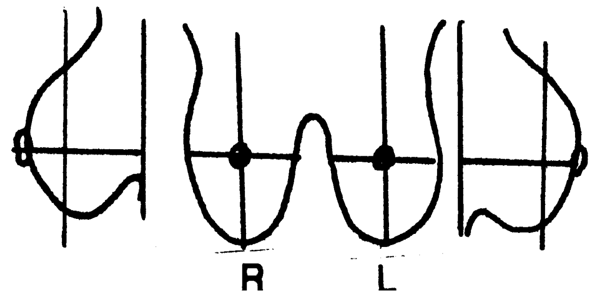
Prominent sternum/ribs_____

Limited Mobility_____

Weight gain/loss since last mammo ____________

Other Notes:

Technologist Printed Name: ___________________



Please mark moles, scars, and sites of previous surgery

Patient Signature: ____ _____________/_____________/_____________

Technologist Signature ONLY I certify I have cleaned mammogram unit before use on this patient. ____ date ________________________