Brookwood Women's Health

SCREENING MAMMOGRAM INFORMATION

Name: _____
Date of Birth: _____
Primary Phone Number: _____

BREAST HISTORY

Date of Last Mammogram: _____ Facility: _____

Have you had breast cancer? ☐ Yes ☐ No ☐ Right ☐ Left

Have you had family members with breast cancer? (specify mother, sister, aunt): _____

Have you personally had cancer of the ☐ Uterus ☐ Ovaries ☐ None ☐ Other

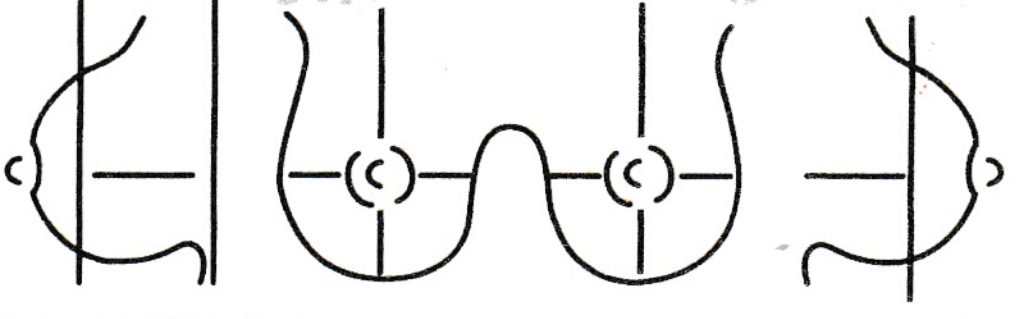
BREAST SURGERY

			DATE
Breast Reduction:	☐ Yes ☐ No	☐ Right ☐ Left	_____
Breast Implants:	☐ Yes ☐ No	☐ Right ☐ Left	_____
Cyst Aspiration:	☐ Yes ☐ No	☐ Right ☐ Left	_____
Needle Biopsy:	☐ Yes ☐ No	☐ Right ☐ Left	_____
Surgical Biopsy:	☐ Yes ☐ No	☐ Right ☐ Left	_____
Mastectomy:	☐ Yes ☐ No	☐ Right ☐ Left	_____
Lumpectomy:	☐ Yes ☐ No	☐ Right ☐ Left	_____
Radiation:	☐ Yes ☐ No	☐ Right ☐ Left	_____
Are you pregnant?	☐ Yes ☐ No		

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

Patient Signature: _____ Date: _____

Bottom portion of this form is for the technologist



O Mole
X Lump
-/-/-/ Scar

Technologist initials & notes: _____ Image count: _____