Brookwood Women's Health

SCREENING MAMMOGRAM INFORMATION

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

Circle One:
Have you had the COVID 19 Vaccine? Y N
If so, which arm? R L

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): ______________

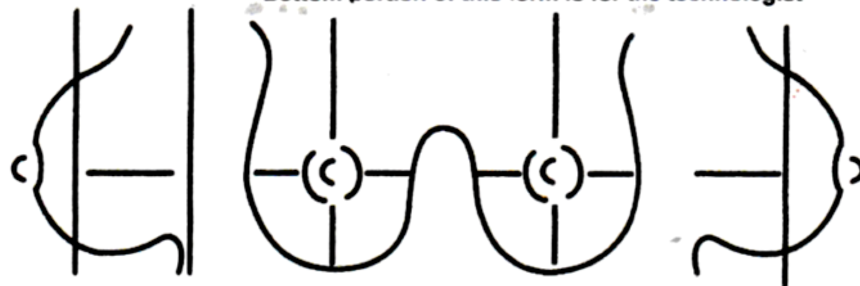
Have you personally had cancer of the ☐ Uterus ☐ Ovaries ☐ None ☐ Other

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: ____________