Brookwood Women's Health, P.C.

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Mammogram Information Sheet

Name: _____ **Age:** _____ **Date of Birth:** _____

Referring Physician: _____ **Patient ID:** _____

Date of last mammogram: _____ **Location of last mammogram:** _____

BREAST SYMPTOMS

☐ **I do not have any new breast symptoms**

		How Long
☐ New breast lump	☐Right ☐Left	_____
☐ Focal breast pain	☐Right ☐Left	_____
☐ Nipple retraction	☐Right ☐Left	_____
☐ Nipple discharge	☐Right ☐Left	_____

Color: Red/ Brown/ Green/ Clear/ Milky
Spontaneous: NO / YES

☐**Other:** _____

BREAST PROCEDURES

	YEAR
Reduction	☐Right ☐Left _____
Implants	☐Right ☐Left _____
Cyst Aspiration	☐Right ☐Left _____
Needle biopsy	☐Right ☐Left _____
Surgical excision - benign	☐Right ☐Left _____
Surgical excision - cancer	☐Right ☐Left _____
Mastectomy	☐Right ☐Left _____
Radiation	☐Right ☐Left _____
Chemotherapy	☐Right ☐Left _____

BREAST HISTORY

Have you had breast cancer? ☐ No ☐Yes - Age at diagnosis: _____ Type of cancer: _____
Family history of breast cancer? ☐ No ☐Yes - Specify Mother, Sister, Daughter & age_____
Abnormal genetic testing? ☐ No ☐Yes - Specify results: _____
Any other type of cancer? ☐ No ☐Yes - Specify type: _____
Have you ever taken hormones? ☐ No ☐Yes - Date started _____If no longer taking, stop date: _____
Are you pregnant? ☐ No ☐Yes
Are you breastfeeding? ☐ No ☐Yes

PATIENT SIGNATURE: _____ **DATE:** _____

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

---------- **BELOW THIS LINE IS FOR TECHNOLOGIST** ----------

EXAM TYPE: ☐ **Screening** ☐**Diagnostic Symptomatic** ☐ **Diagnostic Call Back** ☐ **Follow up**

Was ultrasound performed?☐**Yes** ☐**No**

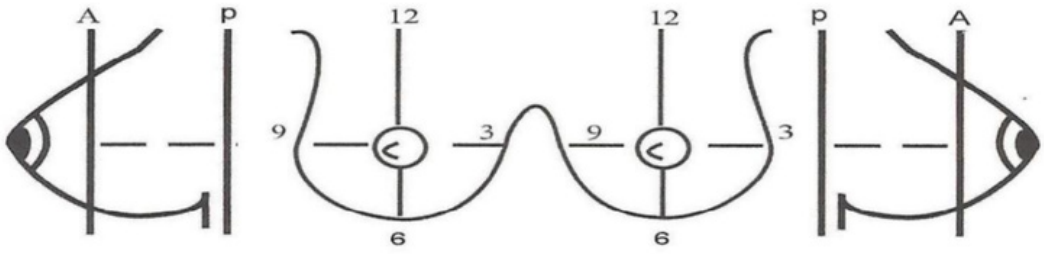
Technologist's notes:

Tech Initials: _____ **Number of Images:** _____

_____

_____

If the exam is for a palpable lesion, mark the palpable abnormality with a Δ in two views on the diagram. If a unilateral exam, cross out the breast that is not imaged.
MARK ALL SURGICAL SCARS ON THE DIAGRAM.



Δ Palpable

-/-/-/- Scar

O Mole