Cardinal Points IMAGING OF THE CAROLINAS

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 ☐ Do you elect to have 3D mammography today? Yes ☐ No ☐

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: _____/_____/_____

Technologist Notes ONLY:

Comments/Positioning Limitations:

Body habitus_____

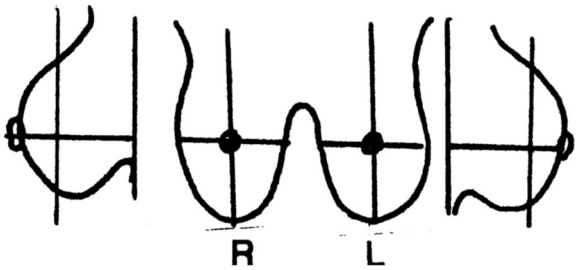
Medial fullness_____

Prominent sternum/ribs_____

Limited Mobility_____

Other:

Technologist Printed Name:



Please mark moles, scars and sites of previous surgery

I authorize release of information, films and copies pertinent to my medical history and for follow-up of any suspicious findings.

Patient Signature: _____ Date: _____/_____/_____

FOR OFFICE USE ONLY: I certify that I have 1) reviewed this form for completeness, 2) scanned this patient history into the RIS and 3) cleaned the mammo unit before use on this patient.

Technologist Signature: _____ Date: _____/_____/_____