



**Screening Mammography Patient Worksheet**

Name: \_\_\_\_\_  
Last First MI

Date: \_\_\_\_\_

Patient ID: \_\_\_\_\_

Address: \_\_\_\_\_

Age \_\_\_\_\_ DOB \_\_\_\_\_

City, St, Zip: \_\_\_\_\_

Physician: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Physician 2: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

No  Yes **Have you had a prior mammogram?**  
If yes, please give date and facility where last mammogram was performed \_\_\_\_\_

No  Yes **Are you currently having any breast problems?**  
If no, please initial: \_\_\_\_\_

If yes, please specify:

	<u>Right</u>	<u>Left</u>	<u>Explain</u>
Lump:	_____	_____	_____
Discharge:	_____	_____	_____
Pain	_____	_____	_____
Skin Changes	_____	_____	_____
Other	_____	_____	_____

No  Yes **Is your appointment today the result of these problems?**

No  Yes **Have you had breast cancer?**  
If yes, which breast? \_\_\_\_\_

No  Yes **Has a first degree relative had breast cancer BEFORE age 50?**  
If yes, check all that apply:  
 Mother  Sister  Daughter

No  Yes **Have you had breast surgery?**  
If yes, please give dates for the following:

	<u>Right</u>	<u>Left</u>
Cyst Aspiration	_____	_____
Needle Biopsy	_____	_____
Surgical Biopsy	_____	_____
Lumpectomy (for cancer)	_____	_____
Mastectomy	_____	_____
Radiation Therapy	_____	_____
Implants	_____	_____
Reduction	_____	_____

No  Yes **Are you presently taking hormone replacement?**  
If yes, how long? \_\_\_\_\_

No  Yes **Are you pregnant?**

**Please check all of the following that are true for you:**

- |  |   |
|--|---|
| <input type="checkbox"/> I do not know my personal breast cancer history | <input type="checkbox"/> I have been through menopause                                      |
| <input type="checkbox"/> I have had endometrial cancer                   | <input type="checkbox"/> I have never had children  |
| <input type="checkbox"/> I have had ovarian cancer                       | <input type="checkbox"/> I had my first child after age 30                                  |
| <input type="checkbox"/> I have the BRCA 1 gene mutation                 | <input type="checkbox"/> I have had previous chest radiation therapy                        |
| <input type="checkbox"/> I have the BRCA 2 gene mutation                 | <input type="checkbox"/> I have had a previous breast biopsy that showed a high risk lesion |
| <input type="checkbox"/> A family member has had ovarian cancer          |   |

Signature \_\_\_\_\_

Date \_\_\_\_\_