SimonMed
See Tomorrow Today

Patient Mammography Form

Please answer ALL questions below

☐ New Patient ☐ Return Patient Appt Date/Time: _____ MRN: _____

Name: _____ Date of Birth: _____ Age: _____

Email address: _____ Cell Phone Number: _____

Are you of the Ashkenzai Jewish Ancestry? ☐ Yes ☐ No Race: _____ Ethnicity: _____

Reason for Exam (Clinical Indications/Signs & Symptoms): _____

Is there a possibility that you may be pregnant? ☐ Yes ☐ No
Have you nursed in the past 6 months? ☐ Yes ☐ No
Are you taking hormones/estrogen? ☐ Yes ☐ No
If yes, how long? _____

Have you had your uterus removed? ☐ Yes ☐ No
Have you had your ovaries removed? ☐ Yes ☐ No
Are you taking birth control pills? ☐ Yes ☐ No
If yes, how long? _____

Are you taking Tamoxifen or other Anti-Estrogen?_____
Date of last breast exam by a doctor or nurse? _____ Age at Menopause: _____

Age at 1st Period: _____ Age at 1st Live Birth: _____ Height: _____Weight: _____

Have you had a breast biopsy? ☐ Yes ☐ No Rt_____Lt_____
If yes, when? _____
Benign(FA,FCC,Papilloma)_____ Pre-Cancer(Atypia, LCIS)____

History of Breast Cancer

Have you had breast cancer? ☐ Yes ☐ No Rt_____ Lt_____
If yes, when? _____ Age at diagnosis:_____
Please circle applicable: DCIS, IDC, ILC
Did you have a Mastectomy? ☐ Yes ☐ No Rt_____ Lt_____
If yes, when? _____
Did you have a lumpectomy? ☐ Yes ☐ No Rt_____ Lt_____
If yes, when? _____
Did you have Chemotherapy? ☐ Yes ☐ No
If yes, when? _____
Did you receive Radiation Treatment? ☐ Yes ☐ No
If yes, when? _____

Have you had:

Breast Augmentation – Implants ☐ Yes ☐ No
If yes, when? _____
Breast Reduction: ☐ Yes ☐ No Breast Lift: ☐ Yes ☐ No
If yes, when? _____
Have you had ovarian cancer? ☐ Yes ☐ No Age at Dx:_____
Chest Wall Irradiation for Lymphoma: ☐ Yes ☐ No Age at Dx:_____

Is there a family history of breast or ovarian cancer? If yes, check which apply:

☐ Mother	☐ Yes ☐ No	☐ Breast	☐ Ovarian	Age: _____
☐ Father	☐ Yes ☐ No	☐ Breast		Age: _____
☐ Sister	☐ Yes ☐ No	☐ Breast	☐ Ovarian	Age: _____
☐ Daughter	☐ Yes ☐ No	☐ Breast	☐ Ovarian	Age: _____
☐ Aunt (Mother's Sister)		☐ Breast	☐ Ovarian	Age: _____
☐ Aunt (Father's Sister)		☐ Breast	☐ Ovarian	Age: _____
☐ Grandmother (Mother's Mother)		☐ Breast	☐ Ovarian	Age: _____
☐ Grandmother (Father's Mother)		☐ Breast	☐ Ovarian	Age: _____
☐ First Cousin (Mother's Side)		☐ Breast	☐ Ovarian	Age: _____
☐ First Cousin (Father's Side)		☐ Breast	☐ Ovarian	Age: _____

I understand that this organization provides breast imaging services and that a qualified radiologist interprets the results. Mammography is only one of the recommended actions for early detection of breast cancer. Not all abnormalities are evident on mammography; therefore, a combination of monthly self-exams, annual mammograms and examinations by a physician is the best and most comprehensive program for the detection of breast cancer.

Patient Signature: _____

Have you had genetic testing for BRCA 1 and 2? _____
If yes, did you test positive for either BRCA gene? _____
Has anyone in your family tested positive for the gene(s), and if so, who?
_____

Do you have any new symptoms?

Breast Lump
Left: ☐ Yes ☐ No If yes, how long? _____
Right: ☐ Yes ☐ No If yes, how long? _____

Pain or Discomfort localized to one area
Left: ☐ Yes ☐ No If yes, how long? _____
Right: ☐ Yes ☐ No If yes, how long? _____

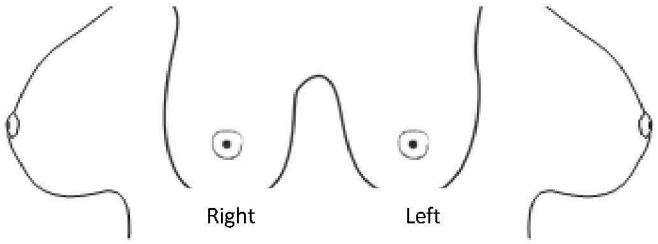
Discharge from Nipple
Left: ☐ Yes ☐ No If yes, how long/color? _____
Right: ☐ Yes ☐ No If yes, how long/color? _____

Inverted Nipple or Skin Dimpling
Left: ☐ Yes ☐ No If yes, how long? _____
Right: ☐ Yes ☐ No If yes, how long? _____

Prior Breast Imaging? If yes, date? ☐ Yes ☐ No
MAMMO _____ US _____ MRI _____
WHERE: _____

*For Technologist Use Only *

Lifetime Risk: _____ **Breast Density:** _____



Technologist Comments: _____