Carolina Breast Imaging Specialists, PLLC — Mammography History Sheet

Patient ID _____ Site ID _____ Patient's Age _____ Date of Birth _____

Last _____ First _____ Middle _____

Referred By _____ Correspondence Language _____

Address _____ City _____ State _____ Zip _____

Phone _____ Phone _____ Race/Ethnicity _____

Height _____ Weight _____ Smoking Status _____
(Indicate Never, Former, or Current)

E-mail Address _____ ☐ Send Correspondence via-Email

Please describe any new problems you are having with your breasts today. _____

Breast Surgical and Treatment History on record:

Breast Cancer History

Have you had breast cancer? ☐ Yes ☐ No

If Yes, please check all that apply if not previously stated:

Date of Diagnosis:	Left	Right	Lumpectomy	Mastectomy	Radiation	Chemo	Hormone Treatment (Tamoxifen, Raloxifene, Arimidex)
_____	☐	☐	☐	☐	☐	☐	_____
_____	☐	☐	☐	☐	☐	☐	_____
_____	☐	☐	☐	☐	☐	☐	_____
_____	☐	☐	☐	☐	☐	☐	_____

Breast Surgical History (Please indicate if not previously stated)

	Left	Right	Date	Outcome
Cyst Aspiration	☐	☐	_____	_____
Surgical Biopsy	☐	☐	_____	_____
Needle Biopsy	☐	☐	_____	_____

Implants

Date _____	Date _____
☐ Saline	☐ Saline
☐ Silicone	☐ Silicone
☐ Pre-pectoral	☐ Pre-pectoral
☐ Retro-pectoral	☐ Retro-pectoral

Other _____

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Gynecological History

☐ Premenopausal ☐ Perimenopausal ☐ Postmenopausal

First Full-term Pregnancy at Age: _____ Hysterectomy at Age: _____ 1st Period at Age: _____ Menopause at Age: _____

Left Ovary was Removed at Age: _____ Right Ovary was Removed at Age: _____ Number of Live Births: _____

History of breast feeding? ☐ Yes ☐ No Last Menstrual Period _____ Last Clinical Breast Exam _____

Could you possibly be pregnant? ☐ Yes ☐ No

Hormone History

Have you ever used or are you currently using any of the following hormones?

Currently Using	Age at First Use	Age at Last Use	Duration Years	Duration Months	Intended Duration
☐ Hormonal Contraceptives					
☐ Progesterone					
☐ Estrogen					
☐ Unspecified					

Personal History of Cancer

Have you previously had any of the following cancers?

Cancer Type	at Age
☐ Ovarian	
☐ Colorectal	
☐ Endometrial	
☐ Other	

Risk Factors

Have you been tested for any of the following cancer genes? ☐ BRCA1 Outcome _____ ☐ BRCA2 Outcome _____ ☐ Other Outcome _____

☐ Ashkenazi Jewish

☐ Previous Chest Radiation Therapy (Not Breast) at Age: _____

☐ Previous Chemotherapy (Not Breast) at Age: _____

☐ Are you Diabetic? ☐ Insulin Dependent?

Family History

Please list any family members with a history of breast, ovarian, pancreatic, uterine, prostate or colon cancer.

Maternal	Paternal	Relative:	Cancer Type	Age at Diagnosis
☐	☐			
☐	☐			
☐	☐			
☐	☐			
☐	☐			

Patient: _____ Technologist: _____

Please Sign Above