ODC OUTPATIENT DIAGNOSTIC CENTER

# MAMMO PATIENT HISTORY FORM

| Date: | | | |
|---|---|---|---|
| Name: | Age: | Date of Birth: 10/1/1980 | |
| Previous names: | | | |
| Address: | City: | Sate: | Zip: |
| Home phone: Work phone: | Cell phone: | | |
| Referring physician: | | | |
| Reason for mammogram/exam: | | | |
| Have you had a previous mammogram: YES NO | Where: | When: | |
| Have you had a prior breast ultrasound: YES NO | Where: | When: | |
| Weight gain or loss since last mammogram: YES NO | Weight: | | |
| Age of first menstrual cycle: | Age of first full term pregnancy: | | |
| Current Medications: | | | |

| YES | NO | | | | | | |
|---|---|---|---|---|---|---|---|
| YES | NO | New breast lump since last mammogram | | LEFT RIGHT BOTH | | How long? | |
| YES | NO | New pain or tenderness | | LEFT RIGHT BOTH | | | |
| YES | NO | Nipple discharge | | LEFT RIGHT BOTH | | Color/How long? | |
| YES | NO | Breast surgery | | LEFT RIGHT BOTH | | When? | |
| YES | NO | Breast needle biopsy | | LEFT RIGHT BOTH | | When? | |
| YES | NO | Implants, If YES when? | | | | | |
| YES | NO | Do you take any type of hormones? | | Type: | | How long? | |
| YES | NO | Have you ever had any breast cancer? **If YES, circle all that apply:** | | | | | |
| | | **Left** Date? | Mastectomy | Lumpectomy | Reconstruction | Chemotherapy | Radiation |
| | | **Right** Date? | Mastectomy | Lumpectomy | Reconstruction | Chemotherapy | Radiation |
| YES | NO | Do you have a family history of breast cancer? **If YES, circle all that apply:** | | | | | |
| | | | **Mother** | **Sister** | **Grandmother** | **Other** | |
| | | Age of diagnosis: | | | | | |
| YES | NO | Do you have a family history of ovarian cancer? **If YES, circle all that apply:** | | | | | |
| | | | **Mother** | **Sister** | **Grandmother** | **Other** | |
| | | Age of diagnosis: | | | | | |

Patient Signature: Date:

**DO NOT WRITE BELOW THIS LINE**

Lump (▼) Scar ( # ) Mole ( O ) Tenderness (↑)

**Nipple Discharge**

- ☐ Spontaneous
- ☐ Not Spontaneous

| YES | NO | Is this patient a suspected victim of abuse? | YES | NO | Is this patient a fall risk? |
|---|---|---|---|---|---|
| YES | NO | Patient tolerated exam? | YES | NO | Patient discharged without complaint? |

| Comments: | | |
|---|---|---|
| | | |
| Technologist: | Date: | Time: |