The Radiology Clinic
208 McFarland Circle, N.
Tuscaloosa, AL 35406

MAMMOGRAPHY PATIENT HISTORY FORM

NAME _____ **X-RAY #** _____

DATE OF BIRTH _____ **AGE** _____ **REFERRING PHYSICIAN** _____

QUESTIONNAIRE

YES	NO	
☐	☐	Have you had a previous mammogram? If yes, where was your last exam done? _____
☐	☐	Have you had a previous ultrasound of your breast(s)? If yes, where? _____
☐	☐	Do you have a previous history of breast cancer?
☐	☐	Do you have a family history of breast cancer? Relationship: _____
☐	☐	Have you had breast surgery? If yes, check all that apply: Type / Which Breast / Date Performed ☐ Biopsy ☐Right ☐ Left ☐ Both _____ ☐ Cyst aspiration ☐Right ☐ Left ☐ Both _____ ☐ Lumpectomy ☐Right ☐ Left ☐ Both _____ ☐ Implant(s) ☐Right ☐ Left ☐ Both _____ ☐ Trauma/tattoos ☐Right ☐ Left ☐ Both _____ ☐ Reduction/Lift ☐Right ☐ Left ☐ Both _____
☐	☐	Are you on any hormone therapy? If yes, what date did you begin?
☐	☐	Have you had any significant weight ☐ gain or ☐ loss?
☐	☐	Are you having any symptoms? If yes, check all that apply. Symptom / Which breast / Description ☐ Lump or thickness ☐ Right ☐ Left ☐ Both ☐ Pain or tenderness ☐ Right ☐ Left ☐ Both ☐ Nipple discharge ☐ Right ☐ Left ☐ Both ☐ Clear ☐ Bloody ☐ Breast skin or nipple changes ☐ Right ☐ Left ☐ Both If so, explain: _____ ☐ Breast disease. If so, explain: _____
☐	☐	Have you had any other type of malignancy? If yes, specify: _____

What is your current menstrual status? ☐ Premenopausal ☐ Permenopausal ☐ Postmenopausal

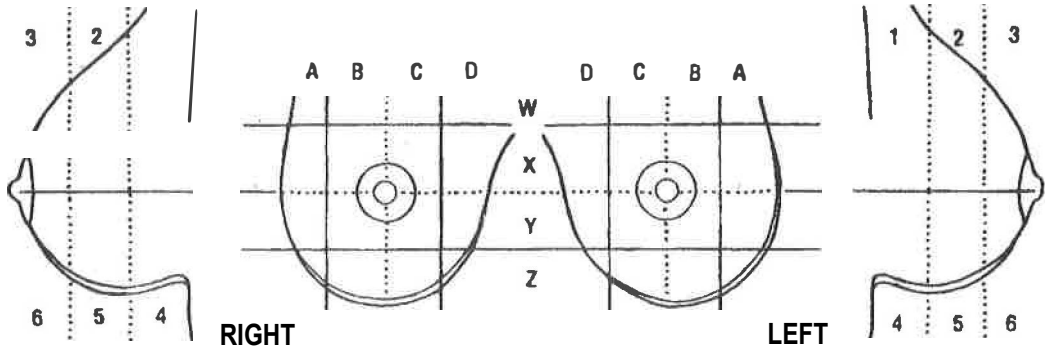
Are you pregnant? ☐ Yes ☐ No
Have had a hysterectomy? ☐ Yes ☐ No
Do you take birth control pills? ☐ Yes ☐ No

Any other symptoms or remarks: _____

IF YOU TAKE AN ASPIRIN OR BLOOD THINNER OF ANY KIND, YOU MAY EXPERIENCE BRUISING ON YOUR BREAST.

Patient's Signature: _____ **Date:** _____ **Phone No.** _____

FOR TECH USE ONLY:



RT. INITIALS: _____