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

MAMMOGRAPHY PATIENT HISTORY FORM

NAME _____ **X-RAY #** _____

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

YES	NO	QUESTIONNAIRE
❒	❒	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? ☐ Lumpectomy ☐ Mastectomy
❒	❒	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 _____ ❒ Implant(s) ❒ 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 ❒ New 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 ❒ Perimenopausal ❒ Postmenopausal

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

Have you received a COVID vaccine? ❒ Yes ❒ No **If yes, when?** _____

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

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

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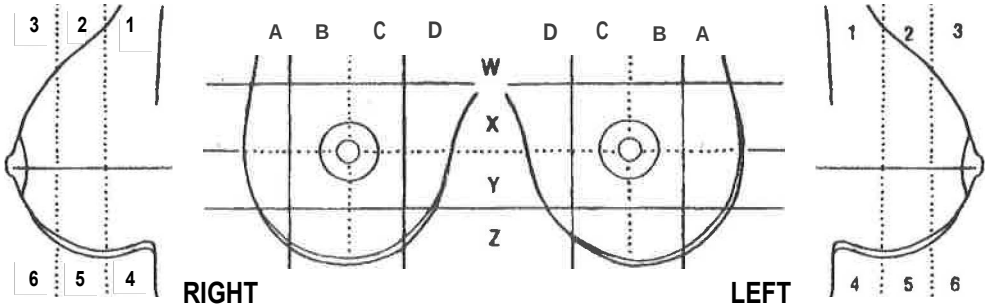

RT. INITIALS: _____