ASSOCIATION OF ALEXANDRIA RADIOLOGISTS

Mammography Patient History

Instructions: Please fill out and sign this form. The technologist will answer any questions you have before your exam. Do not be concerned if you cannot answer some of the questions.

Name:______________________________________ Age:_______ Date of Birth:____________

Have you ever had a mammogram before? No___ Yes___
Where?___________________________________ When?_________________________

Indicate if you are <u>currently</u> having any of the following by marking the affected breast.

	Right	Left	How long/often
Feel a new abnormality (lump or mass) in your breast within the last year	_____	_____	_____________
Specific area of breast pain	_____	_____	_____________
Nipple abnormality	_____	_____	_____________
Breast implant problem	_____	_____	_____________

Are you or could you be pregnant? No___ Yes___
Do you still have a period every month? No___ Yes___ Date of last:___________
Age at start of your period (menarche)? _______
Age at menopause? _______
Number of pregnancies? _______
Number of Births? _______ Age at first pregnancy? ______

Ashkenazi Jewish No____ Yes____

Height:____________ Weight:____________

Personal BRCA history: Tested No____ Yes____
if yes, BRCA 1: Positive _____ Negative ____
BRCA 2: Positive _____ Negative ____

Indicate if you have had any of the following by marking the affected breast.

	Right	Left	When (date)
Breast implants	_____	_____	_____________
Breast reduction	_____	_____	_____________
Breast biopsy (breast tissue taken for analysis)	_____	_____	_____________
Lumpectomy (lump removed for breast cancer)	_____	_____	_____________
Mastectomy (breast removed)	_____	_____	_____________
Radiation/chemotherapy for breast cancer	_____	_____	_____________

Do you have a family history of breast cancer? No_____Yes_______
if yes, what relationship to you:____________________________________
if yes, what type of cancer?______________________Year or age Diagnosed?__________

Tyrer-Cuzick Risk Assessment Calculator

Assess Breast Cancer Risk

This risk calculator asks questions about your personal and family history to determine the possibility of developing breast cancer. The results will display your 10-year risk and your lifetime risk score. The purpose of this tool is simply to inform you. Please consult with your physician should you have any questions about your risk for breast cancer or for guidance on options for breast cancer screening or genetic counseling.

*Would you like to have the Breast Cancer Risk Assessment calculated for you? No______ Yes______

If yes, please complete following questions.

Family history BRCA? No_____Yes_____
If yes, what relationship to you:______________ Positive or Negative:______________

History of reproductive surgery? No___ Yes___
If yes, what type of surgery? ___________________________________

Do you have a personal history of any other cancer? No____ Yes____
If yes, what type of cancer?________________________Year Diagnosed?__________

Do you have a family history of other cancer? No_____Yes_____
If yes, what relationship to you:_________________ Type of Cancer:__________________
relationship to you:_________________ Type of Cancer:__________________
relationship to you:_________________ Type of Cancer:__________________

History of contraceptive use? No___ Yes___ If yes, how long:_______
Type: ______________________________

Are you on hormone replacement therapy? No___ Yes___ If yes, how long:_______
Type:______________________________

About Breast Compression

The compression of the breasts improves the images obtained and reduces the amount of radiation exposure. Compression does not in any way damage breast tissue. A mammogram is the single best method of detecting breast cancers.

Your mammogram will have a second reading by CAD (computer aided detection).

____ __________________________
Patient Signature Date

____

History reviewed: ○ Unit cleaned: ○ Technologist:__________________________________