Summit Radiology
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Mammogram Patient History

Patient Name:	Date of Birth: Sex: F M
Address:	Primary Care Provider
City/Zip Code:	Date of Last Mammogram:
Home Phone: Cell Phone:	Location of Last Mammogram:

Procedures (Mark all that apply)

	Left	Right	Date
Cyst Aspiration	☐	☐	______
Needle Biopsy	☐	☐	______
Surgical Biopsy	☐	☐	______
Lumpectomy	☐	☐	______
Mastectomy	☐	☐	______
Radiation Therapy	☐	☐	______
Chemotherapy	☐	☐	______
Breast Reduction	☐	☐	______
Breast Implant(s)	☐	☐	______

Menstrual History

	Age
First Period	______
Age at time of first live birth	______
Date of last period	______
Menopause	______
Hysterectomy	______

Hormonal History

- Birth Control ☐
- Armidex ☐
- Femara ☐
- Other: ______

Risk Factors (Mark all that apply)

- No family history of breast cancer ☐
- Adopted- family history unknown ☐
- Family history of breast cancer ☐
  (Please circle) Grandmother Aunt Cousin
- Family history of breast cancer ☐
  (Please circle) Mother Sister Daughter
- Pre Menopausal ☐
- Post Menopausal ☐
- Personal history of cancer (list location(s)) ☐

Hormonal Replacement

Have you used hormone replacement therapy? ______

If yes, please answer the following:

		Date(s) Used:
Estrogen	☐	______
Provera	☐	______
Premarin	☐	______
Prempro	☐	______
Tamoxifen	☐	______
Other		______

Indicate all current problems:

- Lump found by physician ☐
- Lump found by you ☐
- Pain ☐
- Implant problem ☐
- Skin changes ☐
- Other ______
- Nipple discharge ☐
- Nipple changes ☐

I authorize release of my prior mammograms to this facility for comparison. If further imaging is needed, I authorize the release of my mammography records to the facility performing the test and for Summit Radiology to receive the results. I authorize Summit Radiology to receive any pathology reports related to my mammograms. I have received the breast health education information: Your Right to Know. I give permission to have this procedure performed. I hereby release Summit Radiology from liability for any adverse effects that may arise from undergoing diagnostic imaging at this time.

Patient Signature: ______________________ **Date:** ______________