

**LAKE POINTE MEDICAL CENTER
MAMMOGRAPHY PATIENT HISTORY FORM**

To help our radiologists interpret your mammogram, please fill out this form completely.

Patient's last name	First/MI	X-Ray#	Date of Birth	Age
Home telephone number	Patient's street address	City	State	Zip
Referring doctor's name	Doctor's address	City	State	Zip

Please indicate Sex F M Medicare Y N

GYNECOLOGICAL HISTORY

Age at which menstrual periods began ___ yrs Age at first full-term pregnancy _____ yrs Number of live births _____
 Age at which menopause was reached ___ yrs Age at which hysterectomy was done _____ and /or ovaries removed _____
 Beginning date of last menstrual period _____

RISK FACTORS

No children Late child bearing (after 30)
 Indicate if you have a history of cancer of the Breast Uterus/Ovaries Colon Other: _____
 Indicate any of the following family members that have had breast cancer.
 Aunt, grandmother or cousin Mother Sister (1) Sister (2) Daughter
 before menopause before menopause before menopause before menopause

BREAST SURGICAL HISTORY

If you have ever had breast surgery or treatment please complete the table below:

BREAST SURGICAL HISTORY							
PROCEDURE / TREATMENT TYPE	MOST RECENT SURGERY			NEXT MOST RECENT SURGERY			Please indicate below the total number of each type of surgery.
	DATE	SIDE	DIAGNOSIS	DATE	SIDE	DIAGNOSIS	
	(Month/Year)	Left/Right/Both	Benign/Malignant	(Month/Year)	Left/Right/Both	Benign/Malignant	
CYST ASPIRATION	(/)	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	<input type="checkbox"/> B <input type="checkbox"/> M	(/)	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	<input type="checkbox"/> B <input type="checkbox"/> M	L__ R__ B__
NEEDLE BIOPSY	(/)	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	<input type="checkbox"/> B <input type="checkbox"/> M	(/)	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	<input type="checkbox"/> B <input type="checkbox"/> M	L__ R__ B__
LUMPECTOMY	(/)	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	<input type="checkbox"/> B <input type="checkbox"/> M	(/)	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	<input type="checkbox"/> B <input type="checkbox"/> M	L__ R__ B__
EXCISIONAL BIOPSY	(/)	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	<input type="checkbox"/> B <input type="checkbox"/> M	(/)	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	<input type="checkbox"/> B <input type="checkbox"/> M	L__ R__ B__
MASTECTOMY	(/)	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	<input type="checkbox"/> B <input type="checkbox"/> M	(/)	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	<input type="checkbox"/> B <input type="checkbox"/> M	L__ R__ B__
RADIATION THERAPY	(/)	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	<input type="checkbox"/> B <input type="checkbox"/> M	(/)	<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	<input type="checkbox"/> B <input type="checkbox"/> M	L__ R__ B__

Other _____
 Check if you have breast implant(s) R L Indicate type: Silicone gel Saline Pre-pectoral
 Augmentation mammoplasty Combination Retro-pectoral
 Check if you have ever had chemotherapy Check if you have ever had a biopsy showing pre-cancerous cells

HORMONE HISTORY

	Oral contraceptives	Estrogen	Progesterone	Tamoxifen
If you have ever taken hormones, please indicate the following:	Age at first use (in years)	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Duration of use (in years)	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Age at last use (in years)	<input type="text"/>	<input type="text"/>	<input type="text"/>

Is this your first mammogram Y N
 If not, where did you have your last mammogram? This facility Other _____
 How long ago did you have this mammogram? _____ years _____ months
 Do you perform regular breast self examinations? Y N

CURRENT COMPLAINTS/SYMPTOMS

Are you having any breast problems now that you think might be pertinent to this examination?
 Breast pain L R Explain _____
 Discharge L R Explain _____
 Lump L R Explain _____
 Other L R Explain _____

Patient Signature _____ Date / / _____ Technologist: _____