



BREAST HISTORY FORM

Patient Identification Label

Last Name: _____ First Name: _____

Physician's to send reports to: _____

Reason for Exam: Routine Screening Follow-up New Symptom: _____

Yes No Have you ever had a mammogram before?
Where: _____ When: _____

Yes No Do you have a family history of breast cancer?
If yes, in which relative(s): Mother, age _____ Grandmother, age _____
 Aunt, age _____ Sister, age _____
 Daughter, age _____ Cousin, age _____

Yes No Personal history of any cancer? Type: _____

Yes No Are you still having menstrual periods? Date of last: _____

Yes No Are you pregnant or nursing?

Yes No Have you had a child? Your age at your first child's birth: _____

Yes No Have you taken any hormone medications? Last date taken: _____
What type: Estrogen Progesterone Birth Control Pills Other

Yes No Have you ever had any of the following procedures?
If yes, which procedure and breast?

<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Right	<input type="checkbox"/> Left	Date: _____
<input type="checkbox"/> Mastectomy	<input type="checkbox"/> Right	<input type="checkbox"/> Left	Date: _____
<input type="checkbox"/> Lumpectomy	<input type="checkbox"/> Right	<input type="checkbox"/> Left	Date: _____
<input type="checkbox"/> Radiation	<input type="checkbox"/> Right	<input type="checkbox"/> Left	Date: _____
<input type="checkbox"/> Implants	<input type="checkbox"/> Right	<input type="checkbox"/> Left	Date: _____
<input type="checkbox"/> Reduction	<input type="checkbox"/> Right	<input type="checkbox"/> Left	Date: _____
<input type="checkbox"/> Biopsy	<input type="checkbox"/> Right	<input type="checkbox"/> Left	Date: _____

Your mammogram results will be mailed to you.
In addition, may we have your permission to call you **if your results are abnormal**? Yes No
Number for us to call: _____

May we leave a message with a person or answering machine instructing you to call us back? Yes No

I have been informed that it is my responsibility to have all prior mammography films, done at another facility or done at Missouri Baptist Medical Center and taken to another facility or doctor's office, available within 72 hours or as soon as possible for comparison with the mammogram being performed today.

Patient Signature: _____ Date: _____

----- **TO BE FILLED OUT BY THE TECHNOLOGIST** -----

_____ Called _____ Left Message _____ No Answer _____ Appointment scheduled

Technologist's Name: _____ Pain Scale: _____

RIGHT



LEFT

DO NOT WRITE BELOW THIS LINE

