UDI WOMEN'S IMAGING CENTER

BREAST MRI
DIGITAL MAMMOGRAPHY
DEXA-BONE DENSITOMETRY
ULTRASOUNDS

MAMMOGRAPHY SCREENING FORM

Last Name	First Name	
D.O.B / /	Age	Phone
Emergency Contact		Phone
When and where was your last Mammogram?		Date

REASON FOR EXAM

Type of exam being performed today? ☐ **ROUTINE SCREENING** ☐ **DIAGNOSTIC**

Do you have any **CURRENT** breast concerns? ☐ YES ☐ NO

If **YES**, please indicate below:	WHICH BREAST?	DURATION?
Lump (New or Enlarging)	L / R	
Tenderness, Discomfort, or Pain	L / R	
Lumpiness (Fibrocystic Changes)	L / R	
Itching	L / R	
Nipple Inversion	L / R	
Nipple Discharge	L / R	
Color? _____ Spontaneous?	Y / N	

Please describe any other symptoms you may be experiencing:

_____

BREAST SURGERY / BIOPSY

Have you ever any breast surgery? ☐ YES ☐ NO

If **YES**, please indicate below:	WHICH BREAST?	APPROXIMATE DATE?
Cyst Aspiration	L / R	
Needle Biopsy	L / R	
Surgical Biopsy	L / R	
Breast Implants	L / R	
Reduction/Lift	L / R	
Lumpectomy for cancer	L / R	
Mastectomy for cancer	L / R	
Radiation/Chemotherapy	L / R	

RISK ANALYSIS

Height _____ **Weight** _____

Has there been significant weight change? ☐ NO ☐ GAIN ☐ LOSS

Age of 1st menstrual cycle: _____

Have you given birth to 1 or more children: ☐ YES ☐ NO

AGE AT FIRST LIVE BIRTH: _____

Have you gone through Menopause: ☐ YES ☐ NO

AGE AT!MENOPAUSE: _____

Have you ever taken hormones (HRT)? If **YES**, for how long?

☐ **Unknown** ☐ **1yr** ☐ **2yrs** ☐ **3yrs** ☐ **4yrs** ☐ **5yrs** ☐ **5+ yrs**

What Type of HRT:

☐ **Unknown** ☐ **Estrogen Only** ☐ **Combined**

If **NOT** CURRENT HRT user, how many years ago did you last use HRT?

☐ **Unknown** ☐ **1yr** ☐ **2yrs** ☐ **3yrs** ☐ **4yrs** ☐ **5yrs** ☐ **5+ yrs**

If **CURRENT** HRT User, how many years do you intend to use HRT?

☐ **Unknown** ☐ **1yr** ☐ **2yrs** ☐ **3yrs** ☐ **4yrs** ☐ **5yrs** ☐ **5+ yrs**

Have you ever been diagnosed with Ovarian Cancer? ☐ YES ☐ NO

AGE AT DIAGNOSIS: _____

Have you ever been diagnosed with any Cancer? ☐ YES ☐ NO

TYPE: _____

Have you ever been diagnosed with Heart Failure (CHF)? ☐ YES ☐ NO

Have you had BRCA (Genetic Testing)? ☐ YES ☐ NO

If **YES**, what were the results? ☐ **Normal** ☐ **BRCA1+** ☐ **BRCA2+**

FAMILY HISTORY of Breast Cancer? ☐ YES ☐ NO

If **YES**, please indicate family member & AGE diagnosed below:

Members of Immediate Family	**Extended Family – Maternal**	**Extended Family - Paternal**

☐ I understand mammograms do not detect all breast cancers and must be combined with periodic physical exam, monthly breast self-exam, and comparison with any prior mammograms.

☐ I understand if I have developed a new breast problem, it is my responsibility to report this to my physician, and also to the technologists at the time of my mammogram.

☐ I attest that the answers I have provided on this form are correct to the best of my knowledge.

PATIENT SIGNATURE: **DATE:**