Patient Label

SWEDISH MOBILE MAMMOGRAPHY

Mammography History Worksheet

DATE: _____

Is this a routine screening mammogram? ☐ Yes ☐ No

If no, what is your concern? ☐ Discharge ☐ Pain ☐ Lump ☐ Other

Are you pregnant? ☐ Yes ☐ No

Have you breast-fed in the last 6 months? ☐ Yes ☐ No

Do you have a personal history of breast cancer? ☐ Yes ☐ No

If yes: Year _____ Side _____

Type of surgery: _____

Chemo? ☐ Yes ☐ No

Radiation? ☐ Yes ☐ No

Hormonal therapy? ☐ Yes ☐ No

Have you had any non-cancer breast surgeries or biopsies?
(For example: reduction, implants, non-cancerous biopsies) ☐ Yes ☐ No

If yes: Year _____ Side _____ Procedure _____

If yes: Year _____ Side _____ Procedure _____

Do you have a history of ovarian cancer or lymphoma? ☐ Yes ☐ No

If yes: Year _____ Type _____

Do you have any family history of breast or ovarian cancer? ☐ Yes ☐ No

If yes: Relationship _____ Type _____ Age at diagnosis _____

Relationship _____ Type _____ Age at diagnosis _____

Have you had a weight ☐ gain or ☐ loss of more than 10 pounds since your last mammogram? ☐ Yes ☐ No

Prior mammograms: ☐ Yes ☐ No

Location: _____ Year: _____

I certify that the information above is complete, correct, and contains all pertinent information for my breast study today.

NAME: Printed _____ Signature _____

SECTION BELOW TO BE FILLED OUT BY TECH

☐ Screening ☐ Coach 1 ☐ Coach 2 Mobile Stop _____

DESCRIBE: _____

_____

_____

_____

Tech Initials: _____