Mammography History Sheet

(office use)

Name: _____ Date of Exam: _____

Date of Birth: _____ Age: _____ Sex: _____ Height: _____ Weight: _____

1. **Do you have any new symptoms since your last breast imaging study, or current symptoms or changes of concern to you?** ☐Yes ☐No

   If yes, do you have any of the following? ☐Lumps ☐Pain ☐Discharge ☐Skin Changes ☐Other ☐None

   When did these symptoms begin? _____

   If other, please specify (include date symptoms began) _____

2. **Sex assigned at birth:**

   ☐Female ☐Male ☐Unknown ☐Not Recorded on Birth Certificate ☐Choose Not to Disclose

   ☐Gender non-confirming ☐Uncertain ☐Intersex

3. **What is your gender identity?**

   ☐Female ☐Male ☐Transgender Female ☐Transgender Male ☐Other ☐Choose Not to Disclose

   ☐Gender non-confirming ☐Something Else ☐Nonbinary

4. **Any significant weight loss?** _____

5. **What is your ethnicity?** _____

6. **Is this your first mammogram?** ☐Yes ☐No

7. **When was the last time a physician examined your breasts?** _____

8. **Is there any possibility that you are pregnant?** ☐Yes ☐No

9. **What is your gynecological history?**

   ☐Premenopausal ☐Perimenopausal *When was your last menstrual cycle?* _____

   ☐Postmenopausal *Menopause at Age?* _____

10. **How old were you when you had your first period?** _____

11. **Please select all breast surgeries that you have had:**

    ☐Lumpectomy ☐Mastectomy ☐Implants ☐Reduction ☐Other_____ ☐None

12. **Have you previously had any of the following cancers?**

    ☐Breast ☐Ovarian ☐Other_____ ☐None

    Have you had treatment for breast cancer? ☐Yes ☐No

    If yes, please select all that apply: ☐Chemotherapy ☐Radiation ☐Surgery

    Year of diagnosis: _____

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13. Have you been tested for any of the following cancer genes? Select all that apply:

☐BRCA 1 ☐BRCA 2 ☐Positive for Other Mutation ☐None

Please specify the outcome _____

14. Any previous breast biopsies? ☐Yes ☐No

15. Any family history of cancer? ☐Yes ☐No

If yes, any family history of breast or ovarian cancer? ☐Yes ☐No

Please complete this section only if your family member(s) had/have a history of breast or ovarian cancer.

Relation to patient: _____ ☐Maternal ☐Paternal

What type of cancer: _____ Age: _____

Genetically tested for: _____ Outcome: _____

Relation to patient: _____ ☐Maternal ☐Paternal

What type of cancer: _____ Age: _____

Genetically tested for: _____ Outcome: _____

Relation to patient: _____ ☐Maternal ☐Paternal

What type of cancer: _____ Age: _____

Genetically tested for: _____ Outcome: _____

16. Previous chest radiation therapy unrelated to breast cancer at age: _____

17. Previous chemotherapy at age: _____

18. Have you ever used or are you currently using any of the following hormones? Select all that apply:

☐Hormonal contraceptive ☐Progesterone ☐Raloxifene ☐Estrogen ☐Tamoxifen ☐Unspecified ☐None

If you used or currently using any of the hormones indicated, please specify:

Age of First Use: _____ Age of Last Use: _____ Duration of Usage: _____ Intended Duration: _____

Patient:

_____

Please sign above

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