MAMMOGRAPHY HISTORY FORM X-RAY #_____

Patient:_____ Date:_____

Age:_____ Date of Birth:_____ Your Physician/Midwife Here:_____

Copy to Primary Care Physician:_____

HAVE YOU EVER HAD:

Mammogram:	**Yes / No**	When_____ Where_____
Breast Ultrasound:	**Yes / No**	When_____ Where_____
Personal history of **breast** cancer:	**Yes / No**	Right____ Left____ Year_____
Personal history of **other** cancer:	**Yes / No**	Primary Site:_____
Family history of breast cancer:	**Yes / No**	**Relationship & age**_____
Personal history of Breast Surgery/Biopsy:	**Yes / No**	Right____ Left____ Year_____
		If yes, what type:_____

DO YOU <u>CURRENTLY</u> HAVE:

Breast pain or tenderness:	**Yes / No**	Right____ Left____ How long?_____
Nipple discharge:	**Yes / No**	Right____ Left____ Color_____
Lump:	**Yes / No**	Right____ Left____ How long?_____
Unusual redness:	**Yes / No**	Right____ Left____
Skin Retraction (puckering)	**Yes / No**	Right____ Left____

ARE YOU TAKING:

Birth control pills:	**Yes / No**	How long?_____
Estrogen (Hormones):	**Yes / No**	How long?_____
Tamoxoifen/Nolvadex:	**Yes / No**	How long?_____
Raloxifen/Evista:	**Yes / No**	How long?_____

ARE YOU BREAST FEEDING NOW? **Yes / No**

Last Period Date_____

Signature:_____

Please answer all the questions.

I hereby authorize the release of any medical, pathology or related information concerning my mammographic examination to Manchester Ob/Gyn Associates.

MAMMOGRAPHY: