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(This information will help to assess your mammogram and advise you and your physician.)

NAME: _____ DATE: _____

BIRTHDATE: _____ AGE: _____ YOUR DOCTOR'S NAME: _____

Have you had a previous mammogram? NO YES = WHEN _____ WHERE _____

REASON FOR MAMMOGRAM TODAY			BREAST HISTORY			
(Please circle "routine" Right or Left for side of problem)			Have you ever had (Please add the year this occurred)			
ROUTINE						
I feel a lump	Right	Left	<input type="checkbox"/> Breast biopsy	Right	Left	Date _____
I feel a thickness	Right	Left	<input type="checkbox"/> Fluid drained from cyst	Right	Left	Date _____
My doctor feels something	Right	Left	<input type="checkbox"/> Cyst removed	Right	Left	Date _____
Nipple discharge	Right	Left	<input type="checkbox"/> Implant	Right	Left	Date _____
New nipple change	Right	Left	<input type="checkbox"/> Breast reduction	Right	Left	Date _____
Pain (other than during cycle)	Right	Left	<input type="checkbox"/> Benign Tumor	Right	Left	Date _____
Dimpling (ripple effect)	Right	Left	<input type="checkbox"/> Cancer	Right	Left	Date _____
Other _____			<input type="checkbox"/> Other _____	Right	Left	Date _____

MENSTRUAL HISTORY:

How old were you when you began having periods? _____ If you stopped having periods, how old were you when you stopped? _____

What was the date of your last period? _____

Have you had a hysterectomy? NO YES = Year _____ Were ovaries removed? YES NO

TERM PREGNANCY HISTORY:

Have you had children? _____ How many? _____ How old were you when you had your first? _____

HORMONE USE:

If you have ever taken birth control pills, at what ages did you use them? _____ to _____

Have you ever used other hormones such as estrogen? (This includes vaginal creams, suppositories, and patches.)

NO YES = Between ages _____ - _____. Presently using them? YES NO

FAMILY HISTORY:

Who, if any, have had breast cancer? No one, Myself, Mother, Sister, Daughter, Aunt, Grandmother.

If your mother or sister has had breast cancer, at what age was it diagnosed? _____

BREAST CANCER TREATMENT HISTORY:

Have you ever had a mastectomy? NO YES = Right / Left

Have you ever had any radiation therapy to breasts? NO YES

Have you ever had chemotherapy? NO YES

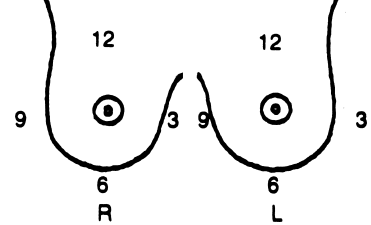
OTHER MEDICAL HISTORY:

Have you ever had (please circle) cancer of the:

Uterus Cervix Ovaries

TECHNOLOGISTS USE ONLY

Scars and Skin Lesions



I hereby authorize Medical Imaging to obtain any of my previous mammograms.

Patient's Signature _____ Date _____ Tech Signature _____