the ODC
OUTPATIENT DIAGNOSTIC CENTER

MAMMOGRAPHY HISTORY FORM

Patient Name: _____ MR#: _____ Date: _____

DOB: _____ Age: _____ Ordering Physician: _____

ALL FEMALES: Date of last menstrual period: _____ Are you or could you be pregnant? ☐ YES ☐ NO

Are you breast feeding? ☐ YES ☐ NO Are you postmenopausal? ☐ YES ☐ NO

YES	NO		
☐	☐	1. Are you pregnant?	
☐	☐	2. Do you have a family history of breast cancer?	**Age Diagnosed:** _____
		(Please Circle) Mother - Sister - Grandmother - Aunt - Daughter	
☐	☐	3. Do you have a history of breast cancer?	**Age Diagnosed:** _____
☐	☐	4. Have you had a mammogram before?	**Approximate Date:** _____
		If yes, where: _____	
☐	☐	5. Have you ever had a breast ultrasound?	**Approximate Date:** _____
		If yes, where: _____	
☐	☐	6. Are you having any of the following symptoms?	

Left	Right		Left	Right	
☐	☐	Palpable lump or thickening	☐	☐	Nipple abnormality
☐	☐	Bloody discharge	☐	☐	Pain
☐	☐	Non-bloody discharge	☐	☐	Other: _____
☐	☐	Skin thickening or dimpling			_____

☐ ☐ 7. Have you had any of the previous breast procedures?

Left	Right		Left	Right	
☐	☐	Cyst aspiration	☐	☐	Implants
☐	☐	Biopsy, needle	☐	☐	Silicone Injections
☐	☐	Biopsy, surgical	☐	☐	Breast reduction
☐	☐	Lumpectomy for cancer	☐	☐	Other: _____
☐	☐	Masectomy			_____
☐	☐	Radiation treatments			

☐ ☐ 8. Are you currently taking Hormones? (Birth control pills, Estrogen, Progestin)

If yes, which ones? _____ Number of years? _____

Patient/Guardian Signature: _____ Date: _____

OFFICE USE ONLY

Tech Comments: _____

_____

_____

_____

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_____

Tech Signature: _____

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