Valley Radiology CONSULTANTS

MAMMOGRAPHY WORKSHEET

Date of Exam:_____

Last Name:		First Name/MI:		DOB:	Age:
Address:		City:	State:	Zip:	
Home Phone:		MRN:	Referring Physician:		

Could you be pregnant? ☐ YES ☐ NO

Risk Factors: Personal history of **Breast cancer:** ☐ YES ☐ NO **Ovarian cancer:** ☐ YES ☐ NO

Family history of breast cancer:	Family history of ovarian cancer:
☐ Mother Approx. Age When Diagnosed:_____	☐ Mother Approx. Age When Diagnosed:_____
☐ Sister 1 Approx. Age When Diagnosed:_____	☐ Sister 1 Approx. Age When Diagnosed:_____
☐ Sister 2 Approx. Age When Diagnosed:_____	☐ Sister 2 Approx. Age When Diagnosed:_____
☐ Daughter Approx. Age When Diagnosed:_____	☐ Daughter Approx. Age When Diagnosed:_____

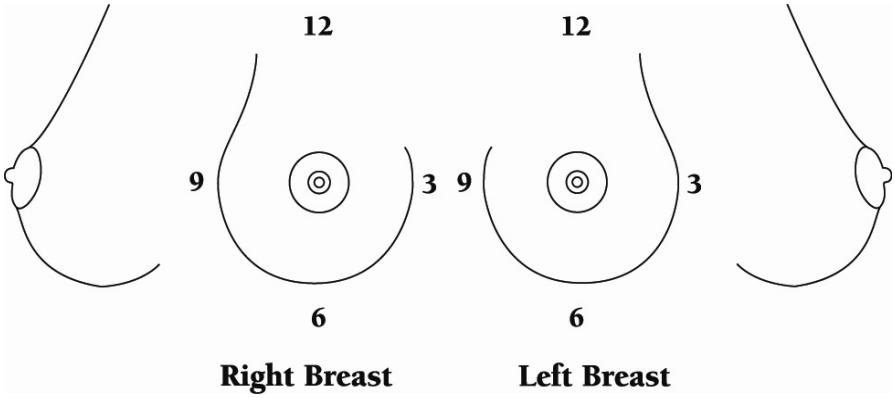
Have you ever had a mammogram?	☐ **YES**	☐ **NO**	**If yes, when?**
	Where:		

Are you having any problems with your breast(s)?

Have you ever had?

1. A biopsy of your breast(s)?	☐ Right or ☐ Left	When:
2. A cyst aspiration (drainage)?	☐ Right or ☐ Left	When:
3. Mastectomy?	☐ Right or ☐ Left	When:
4. Lumpectomy?	☐ Right or ☐ Left	When:
5. Radiation Treatment?	☐ Right or ☐ Left	When:
6. Augmentation (implants)?	☐ Right or ☐ Left	When:
7. Breast Reduction?	☐ Right or ☐ Left	When:

Are you taking any hormones? ☐ YES ☐ NO	Number of years?



Technologist Initials:		**Ultrasound:**	☐ Right or ☐ Left