ZILKHA RADIOLOGY - MEDICAL HISTORY
Mammography

Referring Doctor: _____

Other Doctors you want your results sent to:

_____

_____

Affix Label Here

BREAST IMAGING ONLY: Are you allergic to **Latex**? **YES NO**

1. Reason for your exam today? **First Mammogram/Baseline** **Annual Exam** **Follow-up Exam** **New Breast Problem**
2. Date of Last Mammogram _____Place _____
   (It is the responsibility of the patient to bring prior mammograms from other facilities for comparison purposes)
3. Date YOUR doctor last examined YOUR breasts: _____ Results: _____
4. Are you currently having any breast problems? **YES NO**
   Right: Pain/Tenderness **Lump/Thickening** **Discharge/Bleeding** Duration_____
   Left: Pain/Tenderness **Lump/Thickening** **Discharge/Bleeding** Duration_____
5. Indicate if you have had: **Breast Implants** **Reduction Surgery** To: **RIGHT LEFT BOTH**
   Other Breast Procedure _____ **When** _____
6. Have you ever had a Breast Biopsy? **YES NO**
   Right: Surgical Biopsy **Needle Biopsy** Date_____ Results: **Benign** **Malignant**
   Left: Surgical Biopsy **Needle Biopsy** Date_____ Results: **Benign** **Malignant**
7. Have you ever been diagnosed with breast cancer? **YES NO** If **YES**, how & when was it treated?
   Right: Mastectomy **Lumpectomy** **Radiation Therapy** **Chemotherapy** Date_____
   Left: Mastectomy **Lumpectomy** **Radiation Therapy** **Chemotherapy** Date_____
8. Please indicate which close family member, if any, has had breast cancer and the age it was discovered? **NONE**
   Mother _____ **Sister(s)** _____ **Daughter(s)** _____
9. Has your weight changed significantly since your last mammogram? **GAINED** **LOST** Amount _____

Is there any chance you are pregnant at this time? **YES NO** Signature _____

Age of your first menstrual period? _____ Do you still menstruate? **YES NO** If **YES**, start date of your LMP? _____

If **NO,** at what age did you begin menopause? _____ If applicable, age of your first pregnancy? _____

Are you currently nursing? **YES NO** Have you been breast feeding in the last six months? **YES NO**

SMOKING:

☐ Current; Every Day Smoker ☐ Former Smoker ☐ Smoker; Current Status Unknown
☐ Current; Some Days Smoker ☐ Never Smoked ☐ Unknown If Ever Smoked

If Smoker, How many packs per day? _____ For how many years? _____

Are you taking any medications? NO YES List: _____
_____
_____

Do you have an allergy to medications?
NO YES List: _____
_____

Authorization for Treatment: I hereby consent to treatment by the Radiologist and other medical staff for all radiological tests and/or procedures as deemed medically necessary by my referring physician.

I hereby state that the information listed above is accurate to the best of my knowledge.

Patient or Legal Guardian Signature _____Date_____

Print Patient Name: _____ Date of Birth: _____

For Office Use Only: Co-pay _____ PACS _____ ADS _____ EMR _____

MAMMO_____

DEXA_____

FLXR _____

US_____

CT _____

MR_____

NM_____

XR_____

Affix Label Here

Technologist:

Priors: YES NO

Posting/Coding:

CPT Code(s):

DX:

Did the patient take **FILMS** or **DISC**? Were **FILMS** or **DISC** printed? Send to **EAST** or **WEST**?

ASYMMETRY **YES NO** TENDERNESS **YES NO** NIPPLE DISCHARGE **YES NO**

MASS(S) **YES NO** SKIN MOLES **YES NO** SCAR(S) **YES NO**