Mammography Screening

What is the REASON you are having a breast imaging exam?
(please select one)

- ☐ This is a routine (screening) exam. I am not having breast problems.
- ☐ I am having breast problems: _____
- ☐ This is additional exam requested from a recent study.
- ☐ This is a short interval follow-up request from my last exam *(1-11 months ago).*
- ☐ I have breast implants, but I am not having any problems.
- ☐ This is a review of an outside study.
- ☐ I am going to have breast reduction.
- ☐ I am going to have radiation therapy.
- ☐ This is an additional exam requested from my current screening exam.
- ☐ I have a history of benign breast disease.
- ☐ I have a personal history of breast cancer with breast conservation therapy.

Check all of the following RISK FACTORS that are true for you:

- ☐ No one in my family has had breast cancer
- ☐ My aunt, grandmother, or cousin had breast cancer
- ☐ My mother or sister had breast cancer after their periods stopped
- ☐ My mother or sister had breast cancer while they were still having their periods
- ☐ I do not know my family breast cancer history
- ☐ I have had breast cancer ☐ I have had endometrial cancer
- ☐ I have had a previous breast biopsy that showed a high risk lesion
- ☐ I have been through menopause
- ☐ I have never had children ☐ I had my first child after age 30

If you ever used any of the following Hormones, please enter:

	Age First Used	Duration of Use	Age at Last Use	Currently Using
Hormonal Contraceptives				☐ Yes ☐ No
Estrogen				☐ Yes ☐ No
Progesterone				☐ Yes ☐ No
Tamoxifen				☐ Yes ☐ No
Other: _____				☐ Yes ☐ No

Enter your Menstrual History:

- Age when periods started: _____
- Age at first full term pregnancy: _____
- Age at natural menopause: _____
- Age at hysterectomy: _____
- Age at right ovary removal: _____
- Age at left ovary removal: _____
- Number of lives births: _____

Technologists Notes:

Previous Mammograms? ☐ Yes ☐ No
When _____
Where _____

Do you have Implants?
(If yes, circle L for Left or R for Right)

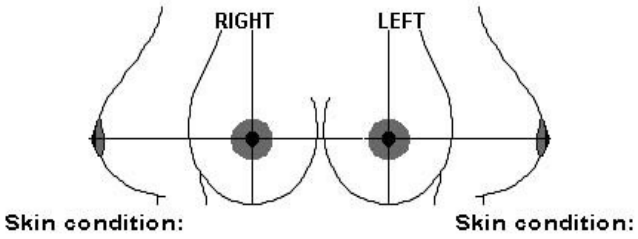
- L R I don't know the specific type
- L R Silicone gel implant
- L R Saline implant
- L R Combination implant
- L R Pre-pectoral implant
- L R Retro-pectoral implant

Previous PROCEDURES? ☐ Yes ☐ No
(Circle L for Left or R for Right)

- L R Cyst aspiration _____
- L R Needle biopsy _____
- L R Excisional biopsy _____
- L R Lumpectomy for cancer _____
- L R Mastectomy _____
- L R Radiation therapy _____
- L R Breast reduction _____
- L R Implant removed _____ *(Date)*

Have you ever received chemotherapy for any type of cancer? ☐ Yes ☐ No

PATIENT SIGNATURE	DATE	TIME
TECHNOLOGIST SIGNATURE	DATE	TIME



Equipment cleaned and disinfected ☐ **Yes** ☐ **No**

PT.NO
NAME
Place EPIC Label Within Box
DOB

UW Medicine
Harborview Medical Center – UW Medical Center
Northwest Hospital & Medical Center – University of Washington Physicians
Seattle, Washington

MAMMOGRAPHY SCREENING
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U3047

WHITE - MEDICAL RECORD

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