

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	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Estrogen	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Progesterone	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tamoxifen	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other: _____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> 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 live births: _____

Technologists Notes:

Equipment cleaned and disinfected Yes No

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)

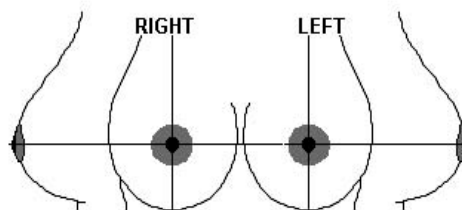
- L R Cyst aspiration _____
- L R Needle biopsy _____
- L R Excisional biopsy _____
- L R Lumpectomy for cancer _____
- L R Mastectomy _____
- L R Radiation therapy _____
- L R Breast reduction _____
- L R Implant removed _____

(Date)

Have you ever received chemotherapy for any

type of cancer? Yes No

PATIENT SIGNATURE	DATE	TIME
TECHNOLOGIST SIGNATURE	DATE	TIME



Skin condition: _____

Skin condition: _____

PLACE PATIENT LABEL HERE

UW Medicine

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

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