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.

I am having breast problems:
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☐ 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:

<table>
<thead>
<tr>
<th>Hormonal Contraceptives</th>
<th>Age First Used</th>
<th>Duration of Use</th>
<th>Age at Last Use</th>
<th>Currently Using</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hormonal Contraceptives</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Estrogen</td>
<td></td>
<td></td>
<td></td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Progesterone</td>
<td></td>
<td></td>
<td></td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Tamoxifen</td>
<td></td>
<td></td>
<td></td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
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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 _________
(_____)

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

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PATIENT SIGNATURE DATE TIME

TECHNOLOGIST SIGNATURE DATE TIME

UW Medicine
Harborview Medical Center – University of Washington Medical Center
UW Neighborhood Clinics – Valley Medical Center
University of Washington Physicians Seattle, Washington

MAMMOGRAPHY SCREENING
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