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.

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 Mammograms? □ Yes □ No
When ____________________
Where ____________________

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>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estrogen</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Progesterone</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tamoxifen</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Enter your Menstrual History:

<table>
<thead>
<tr>
<th>Enter your Menstrual History</th>
<th>Age when periods started:</th>
<th>Age at first full term pregnancy:</th>
<th>Age at natural menopause:</th>
<th>Age at hysterectomy:</th>
<th>Age at right ovary removal:</th>
<th>Age at left ovary removal:</th>
<th>Number of live births:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Technologists Notes:

Equipment cleaned and disinfected □ Yes □ No

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

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

<table>
<thead>
<tr>
<th>Previous PROCEDURES</th>
<th>L R Cyst aspiration</th>
<th>L R Needle biopsy</th>
<th>L R Excisional biopsy</th>
<th>L R Lumpectomy for cancer</th>
<th>L R Mastectomy</th>
<th>L R Radiation therapy</th>
<th>L R Breast reduction</th>
<th>L R Implant removed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

If you 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>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estrogen</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Progesterone</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tamoxifen</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Enter your Menstrual History:

<table>
<thead>
<tr>
<th>Enter your Menstrual History</th>
<th>Age when periods started:</th>
<th>Age at first full term pregnancy:</th>
<th>Age at natural menopause:</th>
<th>Age at hysterectomy:</th>
<th>Age at right ovary removal:</th>
<th>Age at left ovary removal:</th>
<th>Number of live births:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Technologists Notes:

Equipment cleaned and disinfected □ Yes □ No

PATIENT SIGNATURE
DATE
TIME

TECHNOLOGIST SIGNATURE
DATE
TIME

UW Medicine
Harborview Medical Center – University of Washington Medical Center
UW Medicine Primary Care – Valley Medical Center – UW Physicians
MAMMOGRAPHY SCREENING
Page 1 of 1

PLACE PATIENT LABEL HERE