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 live births: _____

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

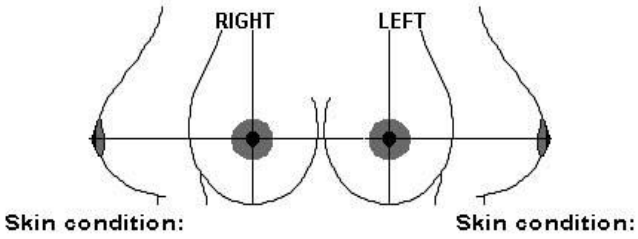
Previous PROCEDURES? ☐ Yes ☐ No
(Circle L for Left or R for Right)

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



Technologists Notes:

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

PLACE PATIENT LABEL HERE

UW Medicine
Harborview Medical Center – University of Washington Medical Center
UW Medicine Primary Care – Valley Medical Center – UW Physicians

MAMMOGRAPHY SCREENING

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