UNIVERSITY DIAGNOSTIC MEDICAL IMAGING, P.C.

MAMMOGRAPHY/BREAST ULTRASOUND HISTORY FORM

Acct# _____

PATIENT: PLEASE FILL OUT COMPLETELY

Name:_____ Date:____/____/____ Sex ☐ F ☐ M Day Time Tel#:_____

Have you received a COVID vaccine? ☐ No ☐ Yes ***IF YES, please answer the following:***

When were you vaccinated? ____/____/____
In which arm? ☐ Left arm ☐ Right arm

Referring Doctor to receive your mammography report _____

When was the last time you saw this doctor? ____/____/____ ☐ ***1+years***

Last time my doctor (GYN or PCP) examined my breast: ____/____/____ ☐ ***1+years***

MEDICAL HISTORY:

Family History of Breast Cancer? ☐ None ☐ Mother ☐ Sister(s) ☐ Daughter
If yes, between what age? ☐ 20-40 ☐ 50's ☐ 60's ☐ Over 70
Personal History of Breast Cancer? ☐ None ☐ Yes ☐ Radiation ☐ Chemotherapy

Prior **RIGHT** Breast Surgery? ☐ None ☐____/____/____ Result _____

Prior **LEFT** Breast Surgery? ☐ None ☐ ____/____/____ Result _____

Breast Implants? ☐ None ☐ Yes-What Type? _____

I was ____ years old when my first child was born. ☐ I have no children

My Last Menstrual Period: ____/____/____ ☐ More than 5 years ago

PURPOSE OF TODAY'S EXAM: ☐ First time ☐ Routine/Yearly ☐ Follow up

MY SYMPTOMS TODAY:

	None	Pain	Lump	Nipple Retraction	Discharge	Other
Right Breast	☐	☐	☐	_____	_____	_____
Left Breast	☐	☐	☐	_____	_____	_____

PREVIOUS MAMMOGRAMS: ☐ No ☐ Yes ***If yes, was it within the last 12 months***? ☐ No ☐ Yes

**Date: ____/____/____ Where: _____ Result: _____

FOR MG/US TECHNOLOGIST'S USE:

MG Tech Initials: _____

NOTES:

US Tech Initials: _____

☐ No Findings ☐ Findings

NOTES: