

**AUSTIN RADIOLOGICAL ASSOCIATION  
MAMMOGRAPHY WORKSHEET**

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**Patient Information: (to be filled out by patient)**

\_\_\_\_\_  
Patient's Last Name

\_\_\_\_\_  
First Name

\_\_\_\_\_  
Previous Last Name

\_\_\_\_\_  
Date of Birth

Have you ever had a mammogram? \_\_\_\_\_

If yes, where and when was it performed? \_\_\_\_\_

Have you ever had breast surgery or other breast procedures? \_\_\_\_\_ If yes, please circle type and list dates:

**Type of Procedure**

**Which Breast**

**Dates Procedures Performed?**

Aspirations

Left or Right

\_\_\_\_\_

Biopsy

Left or Right

\_\_\_\_\_

what type: needle or surgical

Reduction

Left or Right

\_\_\_\_\_

Augmentation (Implants)

Left or Right

\_\_\_\_\_

Mastectomy

Left or Right

\_\_\_\_\_

Lumpectomy (due to Cancer)

Left or Right

\_\_\_\_\_

Radiation Therapy

Left or Right

\_\_\_\_\_

**Personal History**

Have you ever had any type of cancer? \_\_\_\_\_ If yes, what type? \_\_\_\_\_

Has your blood-related mother, sister or daughter ever had breast cancer? \_\_\_\_\_

If yes, who was it and at what age was the diagnosis? \_\_\_\_\_

**Current History**

Any possibility you may be pregnant? Yes / No

Are you currently breastfeeding? Yes / No

Are you currently using hormones? Yes / No If yes, what type and for how long? \_\_\_\_\_

Did your physician refer you for this mammogram? Yes / No

What is the reason for this examination? Please check the most appropriate blanks below:

\_\_\_ **Routine screening, (Well Woman)** I am not aware of any breast problems

\_\_\_ **Not routine**, I have a \_\_\_ breast lump, \_\_\_ skin thickening or dimpling, \_\_\_ nipple changes, \_\_\_ nipple discharge  
\_\_\_ follow-up to recent mammo or breast sono, \_\_\_ other.

Please describe in more detail any areas checked above \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_