AUSTIN RADIOLOGICAL ASSOCIATION
MAMMOGRAPHY WORKSHEET

ACC#: **Site:** **MRN:**
Patient Name: **Date of Birth:** **Gender:** **Exam Date:**

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?
Biopsy	Left or Right	_____ What type? Needle or Surgical
Aspirations	Left or Right	_____
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 First day of last menstrual cycle? _____
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: _____

_____

_____