ARA Diagnostic Imaging MAMMOGRAPHY WORKSHEET

ACC#: _____ Site: _____ MRN: _____

Patient Name: _____ Date of Birth: _____ Gender: _____ Exam Date: _____

Patient Information (to be filled out by patient):

_____
Previous Last Name

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

Have you ever had a mammogram? Yes ☐ No ☐ If yes, where and when was it performed? _____

Have you ever had breast surgery or other breast procedures? Yes ☐ No ☐ If yes, please check type and list dates:

Type of Procedure Dates	Which Breast?	Dates Procedures Performed?	
☐ Biopsy/Aspirations	☐ Left or Right ☐	_____	☐ Needle or Surgical ☐
☐ Reduction/Lift	☐ 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/Family History

Has your blood-related parent, sibling, or child ever had breast cancer? Yes ☐ No ☐

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

Have you ever had any type of cancer? Yes ☐ No ☐ If yes, what type? _____

High Risk Factors

Do you have a known breast related deleterious gene mutation, or do you have a first degree relative with a known gene mutation and have not been tested yourself (Ex. BRCA1/2, Peutz Jeghers, Cowden's)? Yes ☐ No ☐
If yes, explain further.

Have you received radiation therapy to your chest due to cancer before the age of 30? Yes ☐ No ☐

Have you had a breast biopsy with pathology results of atypical ductal hyperplasia (ADH) or a lobular neoplasia (such as ALH or LCIS)? If yes, please explain. Yes ☐ No ☐

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? _____

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**
- ☐ **Nipple discharge and/or changes in nipple**
- ☐ **Follow-up to recent mammo, breast sono, or breast MRI**
- ☐ **Other**

Please describe in more detail any areas checked above: