MAIN STREET RADIOLOGY

Mammography Patient Information

Medical Record # ___________________

Name: ____ Age: __________ Date: _________________

DOB _________________ Home Phone # _________________ Work Phone # _________________________

Previous Mammograms: ☐ Yes ☐ No When: ________________

Where: ☐ NYHQ ☐ Main Street Radiology ☐ Other __________________________

Date of last menstrual period: ________________

When were your breasts last examined by a physician? _______________ Findings: _________________________

REASON FOR TODAY'S EXAM:

☐ Yearly routine ☐ Lump ☐ Skin Changes
☐ Nipple discharge ☐ Swelling ☐ Follow-up for problem/biopsy
☐ Soreness ☐ Pain ☐ Additional imaging from prior/outside study

☐ Other: ____

PREVIOUS BREAST SURGERY: ☐ Yes ☐ No

If Yes, Continue Answering:

		When?	Result
Breast Biopsy:			
☐ Aspiration ☐ Core Needle Bx ☐ Surgical Bx	☐ RIGHT ☐ LEFT	_________________	________________
Mastectomy/Lumpectomy For Cancer	☐ RIGHT ☐ LEFT	_________________	________________
Radiation Therapy	☐ RIGHT ☐ LEFT	_________________	________________
Breast Implants	☐ RIGHT ☐ LEFT	_________________	________________
Other Breast Surgery	☐ RIGHT ☐ LEFT	_________________	________________

CANCER HISTORY:

Family history of Breast Cancer? ☐ Yes ☐ No

If yes, specify whom and give age ☐ Mother _____ (Age) ☐ Daughter _____ (Age) ☐ Sister _____ (Age) ☐ Other: ___________ (Age)

☐ BRCA 1 or 2 ☐ Other: ______________

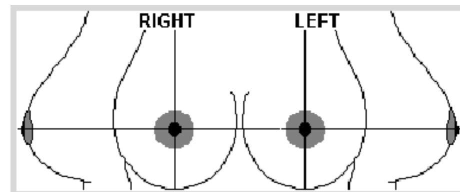
Technologist Section

Mass or Lump ☐ RT ☐ LT

Nipples Inverted ☐ RT ☐ LT

Axillary Masses ☐ RT ☐ LT

Discharge ☐ RT ☐ LT Color___________



Overall Impressions/Comments: ____

KEY: Scars +++ Lumps x Moles ●

Technologist's Signature: ___________________________________

forms/mammography questionnaire