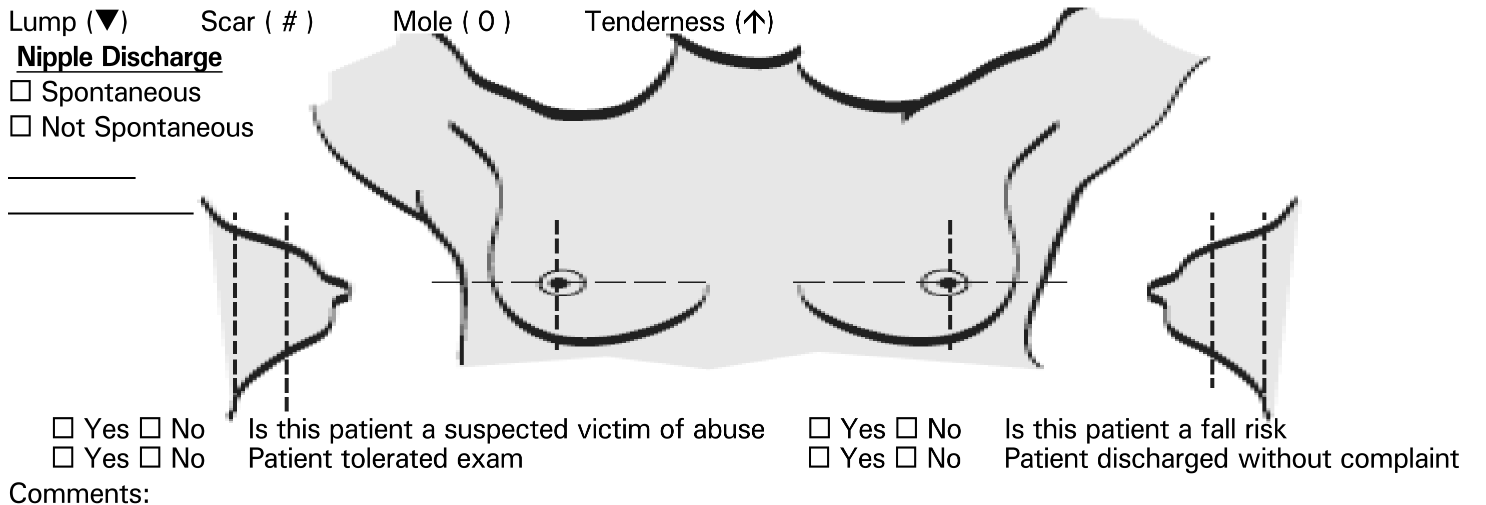
PATIENT HISTORY FORM

Date: ______________
Name: ______________ Age: __________ Date of Birth: ____________
Previous names: ______________
Address: ______________ City: ____________ State: _____ Zip: _______
Home phone: ______________ Work Phone: ______________ Cell Phone: ______________
Referring physician: ______________
Reason for mammogram/exam: ______________
Have you had a previous mammogram: ☐ Yes ☐ No Where: ______________ When: __________
Have you had a prior breast ultrasound: ☐ Yes ☐ No Where: ______________ When: __________
Weight gain or loss since last mammogram: ☐ Yes ☐ No Weight: __________
Age of first menstrual cycle: ______________ Age of first full term pregnancy: ______________
Current Medications: ______________

YES NO
☐ ☐ New breast lump since last mammogram ☐ Left ☐ Right ☐ Both How long? ____________
☐ ☐ New pain or tenderness ☐ Left ☐ Right ☐ Both
☐ ☐ Nipple discharge ☐ Left ☐ Right ☐ Both Color/How long? ____________
☐ ☐ Breast Surgery ☐ Left ☐ Right ☐ Both When? ____________
☐ ☐ Breast needle biopsy ☐ Left ☐ Right ☐ Both When? ____________
☐ ☐ Implants (date: ______________)
☐ ☐ Do you take any type of hormones? Type: ____________ How long? ____________
☐ ☐ Is there any chance you are pregnant?
☐ ☐ Have you ever had breast cancer? **If yes, check all that apply:**
☐ **Left** (Date: ________) ☐ Mastectomy ☐ Lumpectomy ☐ Reconstruction ☐ Chemotherapy ☐ Radiation
☐ **Right** (Date: ________) ☐ Mastectomy ☐ Lumpectomy ☐ Reconstruction ☐ Chemotherapy ☐ Radiation
☐ ☐ Do you have a family history of breast cancer? **If yes, check all that apply:**
☐ **Mother** ☐ **Sister** ☐ **Grandmother** ☐ **Other** ______________
Age of diagnosis: ________ ________ ________ ______________
☐ ☐ Do you have a family history of ovarian cancer? **If yes, check all that apply:**
☐ **Mother** ☐ **Sister** ☐ **Grandmother** ☐ **Other** ______________
Age of diagnosis: ________ ________ ________ ______________

Patient Signature: ______________ Date: ______________

DO NOT WRITE BELOW THIS LINE



Nipple Discharge
☐ Spontaneous
☐ Not Spontaneous
____
____

☐ Yes ☐ No Is this patient a suspected victim of abuse ☐ Yes ☐ No Is this patient a fall risk
☐ Yes ☐ No Patient tolerated exam ☐ Yes ☐ No Patient discharged without complaint
Comments: ______________
____
Technologist: ______________ Date ________ Time: ________

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64830 (3/11)