NAME ____

Doctor Notes ______

E-Mail___________________________

PLEASE CIRCLE YES OR NO:

Have you ever had a mammogram before? Yes No

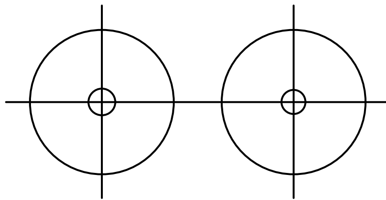
If yes, date ____________________ Facility: ____________________________

Do you feel any breast lump, mass or thickening on Your own physical examination today? Yes No

If yes, which side? Right Left

Doctor Notes ______

Describe and show where on diagram __________________________________



Right Left

Have you **personally** had **breast cancer**? Yes No
If yes, have you had radiation therapy? Yes No

Have you **personally** had any other type of cancer? Yes No
If yes, what type?________________________________

Tech Notes ______

Do you have a **family** history of **breast cancer**? Yes No
If yes, who?____Age_______

Do you have any history of breast surgery? Yes No
If yes, which breast? _________ Year _____________

If yes, what type of surgery? _____________________________________
(Excisional Biopsy, Augmentation , Reduction, Cyst Aspiration, Core Biopsy)

SIGNED ____________________________________DATE ________________