Princeton Radiology
Excellence in Imaging

MAMMOGRAPH

Name: _____ **Age**: _____
(Last) (First) (M)

Did you receive our phone message reminder for your yearly mammogram? ☐ Yes ☐ No
Was this helpful to encourage you to make your mammogram appointment? ☐ Yes ☐ No
Comment: _____

PHYSICAL CONDITION

☐ Yes ☐ No Are you pregnant? Date of last menstrual period _____
☐ Yes ☐ No Have you breast fed within the last 6 months?
☐ Yes ☐ No Are you now taking any type of hormones? If yes, how long _____
☐ Yes ☐ No Do you have breast implants? If yes, type_____

REASON FOR EXAM – PLEASE CHECK:

____ Baseline (No previous mammogram) No Symptoms
____ Routine Yearly Exam – Date and Location of prior exam _____
____ Short Term Follow-up _____
____ Other _____

SYMPTOMS AND HISTORY

☐ Yes ☐ No Do you or your doctor feel a lump? Which breast and for how long? _____
☐ Yes ☐ No Do you have inverted nipples? Which breast and for how long? _____
☐ Yes ☐ No Do you have nipple discharge? Which breast and for how long? _____
☐ Yes ☐ No Any other symptoms? Explain _____
☐ Yes ☐ No Previous breast surgery? If Yes, which breast and when? _____
☐ Yes ☐ No Breast biopsy? _____ Left _____ Right Results were: _____ Benign _____ Malignant
☐ Yes ☐ No Radiation treatments to your breast? Which breast and approximate date?_____

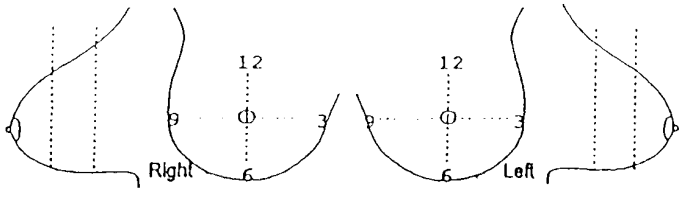
RISK FACTORS

☐ Yes ☐ No Have you had breast cancer? If yes, which breast and age of diagnosis? _____
☐ Yes ☐ No Has any relative ever had breast cancer? Who: _____ Age when diagnosed? _____
☐ Yes ☐ No Have you ever had any other type of cancer? If Yes, type _____
☐ Yes ☐ No Have you ever been tested for the breast cancer gene? Comment: _____
☐ True ☐ False I have never been pregnant.

Occasionally, the results of a Screening Mammogram require patients to return for an additional Diagnostic Mammogram. This is a separate exam that is performed to evaluate an area of concern.

PATIENT SIGNATURE: _____ DATE OF BIRTH: _____

FOR TECHNOLOGIST USE ONLY
↓ DO NOT WRITE BELOW THIS LINE ↓

Date: _____ X-ray Number: _____ Technologist: _____

History/Clinical Symptoms: