MAMMOGRAPHY

Name: ______________________________ **Age:** ______

REASON FOR EXAM – PLEASE CHECK:

☐ Baseline (No previous mammogram) No Symptoms ☐ Routine Yearly Exam ☐ Short Term Follow-up ________

☐ Other:________________ Last Mammo at: ____________ Previous MRI Breast or US Breast? ______________

SYMPTOMS AND HISTORY

☐ 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: ☐ Silcone ☐ Saline

☐ Yes ☐ No Do you or your doctor feel a lump? Which breast and for how long? ______________

☐ Yes ☐ No Do you have inverted nipples or a 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? R#_____ L#______ Results were: ☐ Benign ☐ Malignant ☐ Atypia ☐ DCIS

☐ Yes ☐ No Have you had breast cancer? If yes, ☐ R ☐ L What Type? ______________

☐ Yes ☐ No Radiation treatments to your breast? ☐ R ☐ L What Year? ______________

☐ Yes ☐ No Chemotherapy? Approx Date: __________ Hormonal therapy? Approx Date: _________

☐ Yes ☐ No Have you ever had any other type of cancer? If Yes, type ______________________

RISK FACTORS – Used to calculate a personalized Breast Cancer Risk Assessment (Claus model)

List relatives who have a history of breast or ovarian cancer & their age of onset below:

1st degree relatives	2nd degree relatives Mother's Side	2nd degree relatives Father's Side
Parents, Siblings, Children	*Grandparents, Aunts, Nieces, Half-siblings*	*Grandparents, Aunts, Nieces, Half-sibling*
________ (Relative) Age of Onset:______ ☐ Breast ☐ Ovarian	________ (Relative) Age of Onset:______ ☐ Breast ☐ Ovarian	________ (Relative) Age of Onset:______ ☐ Breast ☐ Ovarian
________ (Relative) Age of Onset:______ ☐ Breast ☐ Ovarian	________ (Relative) Age of Onset:______ ☐ Breast ☐ Ovarian	________ (Relative) Age of Onset:______ ☐ Breast ☐ Ovarian
________ (Relative) Age of Onset:______ ☐ Breast ☐ Ovarian	________ (Relative) Age of Onset:______ ☐ Breast ☐ Ovarian	________ (Relative) Age of Onset:______ ☐ Breast ☐ Ovarian

▶ Do you have or does a first degree relative have the BRCA1 or BRCA 2 gene mutation? ☐ Yes ☐ No

▶ Do you have a history of radiation therapy to the chest between ages 10 and 30 years? ☐ Yes ☐ No

▶ Do you have or does your first degree relative have a history of Li-Fraumeni syndrome, Cowden syndrome or Bannayan-Riley Ruvalcaba syndrome? ☐ Yes ☐ No (If yes, please circle which syndrome)

- **I AUTHORIZE PRINCETON RADIOLOGY TO CALL ME WITH TODAY'S MAMMOGRAPHY RESULTS.**

  CHECK APPRIPRIATE BOX(S)☐ RESULTS GIVEN DIRECTLY TO ME (ONLY) ☐ LEAVE A DETAILE MESSAGE ON MY VOICEMAIL

- AUTHORIZED PHONE NUMBER TO CALL: ☐ CELL ________________ ☐ HOME: ________________

PATIENT SIGNATURE: ______________________________ Date: ____________

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

Date: __________ X-ray #: _________ Tech: __________ CLAUS SCORE: ☐ Less than 20% ☐ Greater than 20%

History/Clinical Symptoms: