COLUMBUS DIAGNOSTIC CENTER
MAMMOGRAM AND BREAST ULTRASOUND HISTORY SHEET

DATE:_____
LAST NAME:_____FIRST NAME_____
Race or Ethnicity?_____Age:_____
What is the best telephone number to reach you?_____

Yes No Are you having any breast problems today?_____
_____

Yes No Have you ever had a mammogram before?
If yes, Where_____Year_____

Yes No Are you pregnant? Age at Menopause_____

Yes No Do you have children?
How old were you when you had: Your first period?___Your first child?___

Yes No Have you breast fed within the past 3 months?_____

Yes No Are you currently taking birth control, fertility drugs or hormones?
What type of hormone? _____What year did you start?_____

Yes No Have you had a weight change of more 10 pounds since your last Mammogram? If yes, how much? Loss_____Gain_____

Yes No Any recent trauma to the breast to cause black and blue skin marks?

Yes No Do you have a family history of breast cancer?
Mother___Age___Sister__Age___Daughter___Age___
Grandmother (Maternal or Paternal)___Age___Maternal Aunt___ Age___

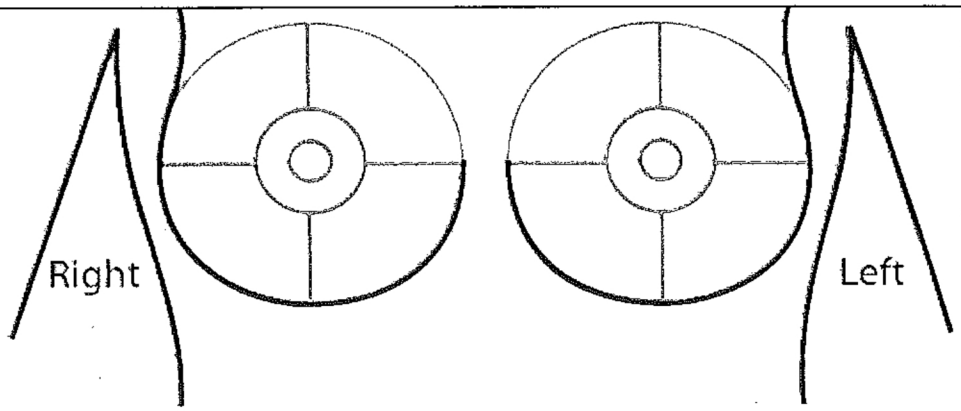
Yes No Have you been diagnosed with BRCA1 or BRCA2 gene?

Yes No Do you have a personal history of breast cancer? If yes, what age?_____

Yes No Have you ever had surgery or a procedure done to your breast?

BREAST CANCER HISTORY			NOT CANCER		
	YEAR	RIGHT/LEFT		YEAR	RIGHT/LEFT
Lumpectomy		RT------LT	Surgical Biopsy		RT------LT
Mastectomy		RT------LT	Needle Biopsy		RT------LT
Reconstruction		RT------LT	Implants		RT------LT
Implants		RT------LT	Reconstruction		RT------LT
Flap		RT------LT	Reductions		RT------LT
Radiation					
Chemotherapy					
Hormone	Tamoxifen Femara	Evista Arimidex	Cyst Aspiration		RT------LT

OFFICE USE ONLY **OFFICE USE ONLY** **OFFICE USE ONLY**



BIRADS