Ocean Medical Imaging
of Delaware
*Radiology you can trust.*

# Mammography Worksheet

**Please complete to the best of your knowledge. The Mammographer will review during the exam.**

**Name:** _____ **Birthdate:** _____
(please print)

Have you or your Physician felt any mass or other abnormality? YES NO
Is this NEW? YES NO
Is your Physician aware? YES NO
How long has it been present? _____
Do you have a personal history of breast cancer? YES NO
If yes, please give dates of treatment: Surgery _____
Radiation _____
Chemotherapy _____

**Is there a history of:**

| | | |
|---|---|---|
| Recent breast pain? | YES | NO |
| Abnormal nipple discharge? | YES | NO |
| Inverted nipple? | YES | NO |
| Breast implants? | YES | NO |
| Significant change in weight? | YES | NO |

**Have you had any Breast Surgery?**
YES NO

RIGHT: _____

LEFT: _____

**MENSTRUATION:**
Age of first MP: _____ Last MP: _____
Hysterectomy: _____ When: _____
HRT's: _____ How long: _____
BCP's _____ How Long: _____

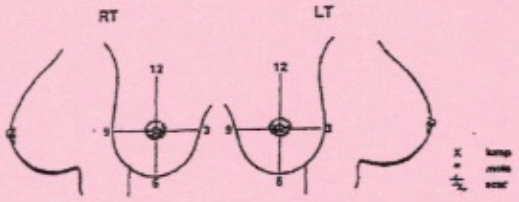
**FAMILY HISTORY of BREAST CANCER:**
Grandmother _____
Mother _____
Sister _____
Daughter _____
Other _____

**PREGNANCY**
How many: _____
Age at 1st pregnancy: _____ Do you think you could be pregnant? _____

**I attest that the above information is correct to the best of my knowledge.**

_____
**Patient Signature** **Date**

**WOULD YOU LIKE TO SPEAK WITH THE RADIOLOGIST?** _____




Previous Mammogram: _____
Location: _____
Tech Notes:

Tech: _____