MAMMOGRAPHY
Valley Imaging Center

Patient ID #____________

Ordering Physician:____________________

Office Phone #:______________________

Exam: ____

PLEASE PRINT

Date: ____________________

Patient Name: _______________________________ Age:____ Sex: Male Female

First MI LAST

DOB: ____________________ Weight: _____________ Height:_______________

Home Phone #: ______________________ Cell Phone #: _______________________

Complaint/Symptoms: ____

____

Lumps?	NO	RIGHT	LEFT	YES
Pain/Soreness?	NO	RIGHT	LEFT	YES
Nipple Discharge?	NO	RIGHT	LEFT	YES

Are you a diabetic? YES NO

Have you ever had a stroke/TIA? YES NO

Do you smoke? YES NO

Do you have asthmas/COPD? YES NO

Are you still Menstruating? YES NO

Age of First Menstrual Cycle? _______

Age of Last Menstrual Cycle? _______

Are you past Menopause? YES NO

Have you had a Hysterectomy? YES NO

Are you on Hormones? YES NO

Have you ever had Breast Cancer? YES NO

Has a family member had breast cancer? YES NO

If yes, what relationship?____

Do you have children? YES NO If yes, how many? __________

If yes, How old were you when you became pregnant for the first time? ______________

Have you ever had breast surgery? YES NO If yes, what kind? __________

____

Do you have breast implants? YES NO If yes, what year? __________

Do you drink caffeine beverages? YES NO How much/often? __________

Where was your last Mammogram done/when? ________________________________

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I understand Mammography is an excellent test for detecting breast cancer, but self examination or an exam by my doctor could detect breast cancers not seen on the mammogram.

Patient Signature:____

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For Office Use Only

Impression:____

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Technologist:__________________