SANDTON RADIOLOGY
Preventive & Diagnostic Imaging

MAMMOGRAPHY HISTORY

Patient name: _____ **Age:** _____ **Date:** _____

1. Breast complaints: (Eg. Discomfort, discharge from nipple, pain, lump, skin moles, thickening)_____
   _____
2. Have you had a mammogram before? _____
3. If yes, when and where? _____
4. Are you pregnant? _____
5. Age of onset of menstruation: _____
6. When was your last menstrual period? _____
7. Are you menopausal? Pre: _____ During: _____ Post: _____
8. How many times have you been pregnant? _____
9. How many live births have you had? _____
10. Age of first pregnancy: _____
11. Did you breastfeed your children? For how long? _____
12. Have you had fertility treatment? _____
13. Do you have lumps in your breast? Right: _____ Left: _____
14. Do you have any discomfort, pain or tenderness in your breast?
    Right: _____ Left: _____
15. Do you have any skin retraction/thickening on your breast?
    Right: _____ Left: _____
16. Do you have any nipple discharge? Right: _____Left: _____
17. Have you had any of the following breast procedures?
    Aspiration: _____ Biopsy: _____ Lumpectomy:_____
    Augmentation: _____ Reduction:_____ Mastectomy:_____
18. Did you have any other surgery? _____
19. Have you ever injured your breasts? _____
20. Is there a family history of cancer? _____ If yes - who? _____
    At what age?_____ What cancer? _____
21. Do you take any caffeine? _____
22. Do you smoke or use tobacco products? _____
23. Are you taking any medication? ____ If yes, please specify:_____
24. Are you on any hormone treatment (oestrogen, progesterone, DHEA, homeopathic)?
    Please specify: _____

THANK YOU FOR YOUR COOPERATION!