MAMMOGRAPHY FACT SHEET

Name:_____(PLACE STICKER HERE) __ _____ ____

ARE YOU HAVING ANY CURRENT BREAST SYMPTOMS? YES _____ NO _____

IF YES, INDICATE:	RIGHT	LEFT
TENDERNESS	_____	_____
BURNING	_____	_____
NIPPLE DISCHARGE	_____	_____
SKIN DIMPLING	_____	_____
LUMP	_____	_____
INVERTED NIPPLE	_____	_____
OTHER	_____	_____

HOW MANY PREGNACIES HAVE YOU HAD? _____
HOW MANY FULL-TERM PREGNANCIES HAVE YOU HAD? _____
WHAT WAS YOUR AGE AT FIRST CHILDS BIRTH? _____
DID YOU BREAST FEED? _____
AGE AT YOUR FIRST PERIOD _____
DATE OF LAST MENSTRUAL PERIOD or AGE AT MENOPAUSE _____

	YES	NO
ARE YOU PREGNANT NOW?	_____	_____
ARE YOU TAKING ORAL CONTRACEPTIVES?	_____	_____
HAVE YOU HAD A HYSTERECTOMY? COMPLETE OR PARTIAL? (PLEASE CIRCLE)	_____	_____
HAVE YOU HAD CANCER OF ANY KIND? **IF YES, WHAT TYPE(S)? _____**	_____	_____
ARE YOU TAKING ANY HORMONES? **PLEASE LIST:_____**	_____	_____
DO YOU HAVE BREAST IMPLANTS? **IF YES, SILICONE or SALINE? IN FRONT OF, or BEHIND THE MUSCLE?** **(PLEASE CIRCLE) (PLEASE CIRCLE)**	_____	_____
HAVE YOU EVER HAD BREAST SURGERY, CYST ASPIRATION or BIOPSY? **(PLEASE CIRCLE)** **WHICH BREAST _____ APPROX DATE _____**	_____	_____
HAVE YOU EVER HAD RADIATON THERAPY or CHEMOTHERAPY? (PLEASE CIRCLE)	_____	_____
HAVE YOU HAD A MAMMOGRAM BEFORE? **DATE:_____ PLACE:_____**	_____	_____
HAS ANYONE IN YOUR FAMILY HAD BREAST or OVARIAN CANCER? (PLEASE CIRCLE) **MOTHER_____ DAUGHTER_____** **SISTER _____ OTHER _____**	_____	_____
DO YOU PRACTICE BREAST SELF-EXAM?	_____	_____
DO YOU SMOKE CIGARETTES?	_____	_____
HAVE YOU MET WITH DR. DECK OUR BREAST SPECIALIST, IN THE LAST YEAR?	_____	_____
HAVE YOU HAD A BREAST MRI IN THE LAST YEAR?	_____	_____
HAVE YOU HAD *BRCA* TESTING?	_____	_____