Patient's Name: **Date of Birth:**

Email Address:

By providing your email address, you consent to receive occasional emails from Pinehurst Radiology regarding products and services. Cell Phone is in the event we need to contact you.

Cell Phone:

*Please fill in the information by **circling** the correct answer:*

1. Are you presently taking hormones or oral contraceptives?	NO YES	
2. Do you still have a menstrual cycle?	NO YES	If no: Age of Hysterectomy/Menopause
3. Do you have a personal (yourself) history of breast cancer?	NO YES	RIGHT LEFT
4. Do you have a family history of breast cancer?	NO YES	
If yes,	Mother Sister Daughter	Age of diagnosis:
5. Have you ever had surgery or a biopsy on your breast?	NO YES	RIGHT LEFT
○ If Benign (not cancer):	Needle Biopsy Surgical Biopsy	When:
○ If Cancer:	Lumpectomy Mastectomy Radiation Therapy	When:
○ If Implants:	Silicone Saline	When:
○ If Breast Reduction:	When:	
6. Are you having problems with your breast?	NO YES	How long?
○ Lump:	RIGHT LEFT BOTH	
○ Discharge:	RIGHT LEFT BOTH	Color:
○ Other:	RIGHT LEFT BOTH	Specify:
7. Are you pregnant or nursing?	NO YES	
8. Have you had a previous mammogram?	NO YES	When:
	Where:	

Patient Signature **Date**

Screening Diagnostic ***OFFICE USE ONLY***

_____ I was informed about the change in my Mammogram from Screening to Diagnostic