PINEHURST RADIOLOGY

Patient's Name (print): _____

Date of Birth: _____ **Age:** _____ **Cell Phone:** _____

Have you ever had a mammogram? YES NO Where? _____ **When:** _____

PERSONAL INFORMATION	
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 family history of breast cancer?	NO YES
	If yes: Mother Sister Daughter Age of Diagnosis:
4. Are you pregnant or nursing?	NO YES

PERSONAL SURGICAL HISTORY		
1. Have you ever had biopsy or cyst aspiration on your breast?	NO YES	RIGHT LEFT
• If **Benign** (not cancer)	NEEDLE SURGICAL	When:
• If **Cancer**	LUMPECTOMY MASTECTOMY RADIATION THERAPY	When:
2. Do you have breast implants?	NO YES If yes: SILICONE SALINE	When:
3. Have you had a breast reduction and/or lift?	NO YES	When:

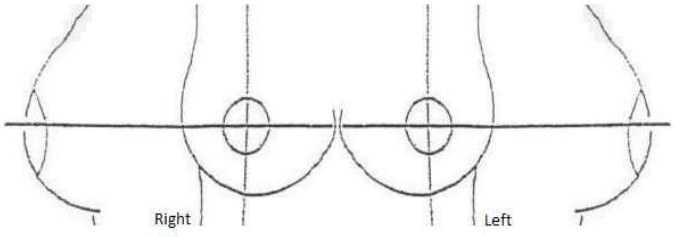
Are you having any **CURRENT/NEW** problems with your breast?	NO YES	How long:
• Lump:	RT LT	
• Discharge	RT LT	Color:
• Other:	RT LT	Specify:

Patient Signature: _____ **Date:** _____

DO NOT WRITE IN THIS BOX

Number of images _____

SCREENING **DIAGNOSTIC** **TECH:** _____ **MRN:** _____



☐ Baseline ☐ Hold for priors

☐ The "post biopsy mammogram for marker placement" lay summary was given to the patient.

☐ STAT _____

_____ I was informed about the change in my mammogram screening to diagnostic.