Weill Cornell Imaging at NewYork-Presbyterian
MAMMOGRAPHY WORKSHEET

Tech Initials:

Patient ID _____

Last _____ First _____ MI ___ DOB _____

Referred by _____ Age _____

Demographics

Address _____

_____

City _____ State _____

Zip _____ Country _____

Sex ☐ Female ☐ Male

Height ___ ft ____ in   Weight ____ lbs

Ethnicity _____

Home phone _____ Work phone _____ x _____ Cell Phone _____

Email Address _____

► **Current Complaints/Symptoms** _____

► ☐ This is my first mammogram   ► Time since last mammogram ____ yrs ____ mos ☐ <1 mo

► Last menstrual period _____

► Are you or could you be pregnant? ☐ Yes   ☐ No

► When was your last clinical breast exam? _____

► **Breast Surgical and Treatment History** Include date, type, and result (ex. Mastectomy, Lumpectomy, Biopsies, Radiation, etc.)

_____

_____

_____

_____

► Personal Risk Factors

at Age

☐ Ashkenazi Jewish
☐ History of breast cancer _____
☐ History of ovarian cancer _____
☐ History of other cancer _____
☐ History of high-risk lesion _____
☐ Previous chest radiation therapy _____
☐ Previous chemotherapy _____

► Family History of Breast or Ovarian Cancer

Relative	at Age	Pre-menopause	Cancer Type	Maternal	/ Paternal
_____	____	☐	_____	☐	☐
_____	____	☐	_____	☐	☐
_____	____	☐	_____	☐	☐
_____	____	☐	_____	☐	☐
_____	____	☐	_____	☐	☐

► Personal and Family Genetic Testing

☐ Genetically tested?
Outcome _____ Gene type _____

☐ Family member genetically tested? Relative _____
Outcome _____ Gene type _____

► Gynecological History

First menstrual period at age _____   Number of live births _____   First full-term pregnancy at age _____

Menopause at age _____   Left ovary removed at age _____   Right ovary removed at age _____   Hysterectomy at age _____

► Breast Implants

☐ Right Date _____   ☐ Left Date _____

► Hormone History

	Currently Using	Age at First Use	Age at Last Use	Duration of use	
Oral Contraceptives	☐	_____	_____	_____ yrs	_____ mos
Estrogen	☐	_____	_____	_____ yrs	_____ mos
Progesterone	☐	_____	_____	_____ yrs	_____ mos
Tamoxifen	☐	_____	_____	_____ yrs	_____ mos
Raloxifene	☐	_____	_____	_____ yrs	_____ mos
Unspecified hormones	☐	_____	_____	_____ yrs	_____ mos

► I certify that the above information is correct to the best of my knowledge.

Patient Signature: _____   Date: _____   *Copyright 2014 MRS, Inc.*