GUILFORD RADIOLOGY
Imaging Excellence with Personalized Care

MAMMOGRAPHY HISTORY SHEET

Patients Name: _____ Date ___/____/_____

Date of Birth: ____/____/_____ MRN #: _____

Reason for exam: Routine ____ Other: _____

Prior mammograms: Yes ____, if so where? _____ When? _____

Outside films requested: _____ Received: _____

Baseline: _____

Radiation Treatment to the chest or abdomen? _____

Menopause? _____ HRT? _____ How long? _____

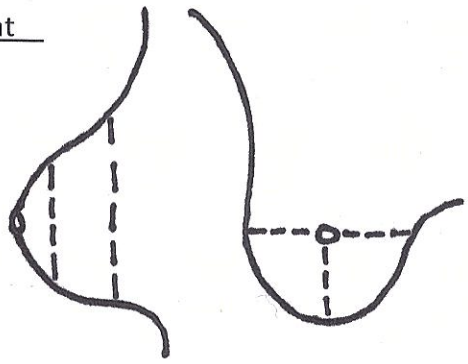
	Right	Left	Dates/Comments
Cyst Aspiration	_____	_____	_____
Benign Biopsy	_____	_____	_____
Lumpectomy	_____	_____	_____
Mastectomy	_____	_____	_____
Radiation Therapy	_____	_____	_____
Implants/Reductions	_____	_____	_____
Scars/moles/masses	_____	_____	_____

Family History of Breast cancer (please note approximate age of onset):

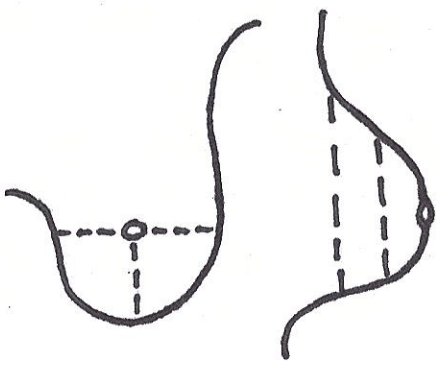
Mother _____ Sister _____ Daughter _____ Other _____

No family history of breast cancer _____

Right



Left



Risk Factor

Comments: _____

_____

_____

Tech Initials _____