anatomi imaging
a Via Christi Health Partner

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Wichita, KS
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Mammography Examination

Last Name _____ First Name _____ M.I. ___

Appointment Date _____ Location _____
YYYY-MM-DD

Date of Birth _____ Age: _____ Referring Physician: _____

Have you had a previous mammogram? ..... ◯Yes ◯No

If yes, and the procedures were done elsewhere, please complete the "Recent Mammograms" section at the bottom of this form.

Have you had previous breast cancer? ..... ◯Yes ◯No

Have you had previous breast surgery? ..... ◯Yes ◯No

If yes, please check the procedures you have had, and provide the following information:

	Right	Left	Date
☐ Biopsy	☐	☐	_____
☐ Cyst Aspiration	☐	☐	_____
☐ Mastectomy	☐	☐	_____
☐ Implants	☐	☐	_____
☐ Reduction	☐	☐	_____
☐ Other: _____	☐	☐	_____

Are you still having periods? ◯Yes ◯No When did you start having periods? _____

If yes, date of last period: _____ If no, when did your periods stop? _____

Have you ever been pregnant? ◯Yes ◯No If yes, your age at first birth: _____

How many pregnancies? _____ How many births? _____

Have you taken estrogen or other hormones? ◯Yes ◯No If yes, for how long: _____

Date Started: _____ Date Stopped: _____

Has anyone in your family been diagnosed with breast cancer? ..... ◯Yes ◯No

If yes, please check which family member(s), and provide their age at diagnosis:

- ☐ Grandmother _____
- ☐ Mother _____
- ☐ Aunt(s) _____
- ☐ Sister(s) _____
- ☐ Daugher(s) _____
- ☐ Other: _____ _____

Do you currently have any of the following symptoms?

	Right	Left
☐ Nipple Discharge	☐	☐
☐ Inverted Nipple	☐	☐
☐ Lump or Mass	☐	☐
☐ Pain	☐	☐

Recent Mammograms: Please provide the date, facility, location, address, and phone number for your two most recent mammogram(s).

1)

2)

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