CASCADE RADIOLOGY
EXCELLENCE IN HEALTHCARE, IMAGING & SERVICE

Mammography Patient Information Sheet

Complete and Fax to (770) 980-8975

Name____**Date**__________________________
DOB/AGE_________________________**Physician**____

Reason for Appointment:
Baseline (1st mammogram)____ Screening____ Diagnostic____ Recall____ Follow-Up_____

PREVIOUS MAMMOGRAM: Date ___/___/___ Location _________________________________

PATIENT HISTORY:
# of Pregnancies_____________ Age of first delivery____________________________
Age started period___________ LMP____
Hysterectomy: Yes____ No____ Ovary Removal: Yes____ No____
Menopause: Yes____ No____ Birth Control Pills: Yes____ No____
Hormones: Yes____ No____ Medication Allergies __________________________

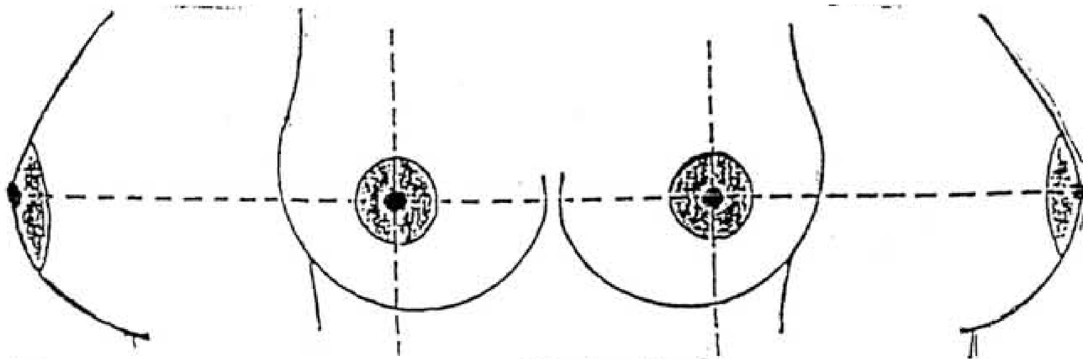
FAMILY HISTORY OF BREAST CANCER:
Self____ Mother____ Sister____ Daughter____ Grandmother: (M) __ (P) __Aunt: (M) ___ (P) ___
N/A_____

PREVIOUS BREAST SURGERY & PROCEDURES:
Biopsy or Lumpectomy: Date___/___/___ Right___ Left___
Findings: Positive____ Negative____
Mastectomy: Date___/___/___ Right___ Left___
Cyst Aspiration: Right ____Left ____
Augmentation (Implants): Date___/___/___ Right___ Left___
Reduction: Date___/___/___ Right___ Left___

NIPPLES:
Normal_____ Flat _____ Inverted ____ Discharge _____

PROBLEMS:
LUMPS: Right___ Left___ How Long? ____
TENDERNESS: Right___ Left___How Long? ____

PATIENT STATES: Technologist Use Only



Radiologist_________________________________ Technologist_________________________

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