MAMMOGRAPHY HISTORY

Date: _____

Name & Surname: _____
Date of birth: _____**Age**: _____

Breast Complaints: _____

_____

1. Have you had a mammogram before?			
2. When and where?			
3. Are you pregnant?			
When was your last menstrual period?			
4. Menopause: Pre: During:	Post:		
5. No of pregnancies: _____	No of live birth: _____		
6. No of pregnancies before 30: _____	No after 30: _____		
7. Did you breastfeed your children and for how long?			
		Yes	**No**
8. Do you have lumps in your breasts?	**R** ight		
	Left		
9. Do you have any discomfort pain or tenderness in your breasts?	**R** ight		
	Left		
10. Do you have any skin retraction / thickening on your breasts?	**R** ight		
	Left		
11. Do you have any nipple discharge?	**R**ight		
	Left		
12. Did you have any previous breast surgery/ biopsy?			
13. Did you have any other surgery?			
14. Do you have relatives with cancer?			
15. Do you take any caffeine?			
16. Do you smoke/snuff?			
17. Are you taking medication / Hormone therapy?			

Indicate:	Lumps ○	Scars ~~III~~	Moles ☼