MAMMOGRAPHY HISTORY

Date: _____

Name & Surname: _____

Date of birth: _____ **Age**: _____

Breast Complaints: _____

_____

1. Have you had a mammogram before?			
2. When and where?			
When was your last menstrual period?			
4. Are you going through, or have you been through Menopause?			
5. No of pregnancies: _____ No of live birth: _____			
6. Have you had any assisted pregnancies?			
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. Have you had you have any previous breast surgery/biopsy?			
13. Have you had any other gynaecological surgery?			
14. Do you have relatives with cancer?			
15. Do you take any caffeine?			
16. Do you smoke/vape?			
17. Are you taking medication?			
18. Are you taking hormone replacements?			

19. Please indicate: Lumps ○ Scars ⫼ Moles ☼