SPRING HILL
IMAGING CENTER

Mammography

Name: _____ Date of Birth: _____ Height: _____ Weight: _____ Hispanic Yes [ ] No [ ]

Referring Physician _____

When and where was your last mammogram?

_____

_____

Have you ever had any type of cancer? (if yes, when and what type)

_____

_____

Is there any family history of Breast Cancer? (if yes, what relation to you and at what age were they diagnosed)

_____

_____

How old were you when you had your first period?

_____

When was your last period?

_____

Hysterectomy at age _____Partial or Complete

Left ovary removed at age _____ Right ovary removed at age _____

Did you ever take birth control pills or hormones? Yes [ ] No [ ]

If yes, what type(s)? _____

How many years? _____

How many live birth pregnancies did you have? _____

Were you over the age of 35 with any of your pregnancies? Yes [ ] No [ ]

How old were you when you had your first child? _____

Have you ever had any type of surgery on your breast? Yes [ ] No [ ]

If so: Right or Left; when and what type? _____