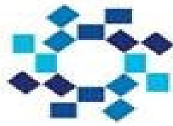


***Women's Breast Center***

**Mammography Worksheet**

**Phone number(s)**

Name: ___________________________

home # __________________________

cell # __________________________

work # __________________________

Prior mammogram Where? ______________________________ When? ________________

**Current Complaints/Symptoms/reason for exam**

☐ lump
☐ Pain
☐ Nipple Discharge
☐ Other

☐ SCREENING Z12.31
☐ no breast complaints
☐ DENSE BREAST R92.2

☐ DIAGNOSTIC
☐ additional images R92.8
☐ short term follow up
☐ h/o ca, lumpectomy 5 years

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

| **Hormone History** | Currently using | Duration of use |
|---|---|---|
| ☐ Oral Contraceptives | __________ | ____yrs ____mos |
| ☐ Estrogen | __________ | ____yrs ____mos |
| ☐ unspecified hormones | __________ | ____yrs ____mos |

Patient Signature ________________________________

Tech's Initial ________________________________

Hackensack Meridian *Health*
Mountainside Medical Center

***Women's Breast Center***
**Mammography Worksheet**
**Personal & Family History Chart**

MR# ______________________

Name: ______________________________________ DOB: _____________________

## Personal Risk Factors

- ☐ History of breast cancer
- ☐ History of ovarian cancer
- ☐ History of endometrial cancer
- ☐ History of colon cancer

## Family History of Cancer

| Relative | Type | Age |
|---|---|---|
| _______________ | _____________ | ______ |
| _______________ | _____________ | ______ |
| _______________ | _____________ | ______ |
| _______________ | _____________ | ______ |

## Gynecological History

Menopause at age _______ First full term pregnancy at age _______

Number of live births _________Hysterectomy age ________

## Breast Surgical and Treatment History

| Date | Surgical and Treatment | Laterality | Pt's initial | Tech's Initial |
|---|---|---|---|---|
| ______ | ______________________________ | ______ | __________ | __________ |
| ______ | ______________________________ | ______ | __________ | __________ |
| ______ | ______________________________ | ______ | __________ | __________ |
| ______ | ______________________________ | ______ | __________ | __________ |
| ______ | ______________________________ | ______ | __________ | __________ |
| ______ | ______________________________ | ______ | __________ | __________ |
| ______ | ______________________________ | ______ | __________ | __________ |
| ______ | ______________________________ | ______ | __________ | __________ |
| ______ | ______________________________ | ______ | __________ | __________ |
| ______ | ______________________________ | ______ | __________ | __________ |

Mammo History

Image Documentation (Breast Complaints)

History ( Family h/o ca, OB/Gyn, Medical, biopsies, & surgeries)
OB/Gyn Status (LMP, pregnancy, & breastfeeding)
Notes
Implants (end exam)

Hackensack
Meridian *Health*
Mountainside
Medical Center

## *Women's Breast Center*

**PREGNANCY EVALUATION AND CONSENT FORM**

Name: ______________________________

In order to fully evaluate your medical condition your doctor has requested that the following x-ray examination(s) be performed

__________________________________________________________________________

__________________________________________________________________________

**Last menstrual period** _____________

**Are you now, or is it possible that you might be pregnant? YES NO**

IF YES, how many weeks / months: _______________________

**Have you breast fed in the past 3 months YES NO**

Your doctor has that the requested examination (s) are necessary in determining your medical diagnosis .
It is his medical opinion that the benefits of the examination (s) are greater than the possible risk.
If the examination will allow, precautions may be taken by shielding the abdomen.

1. To the best of my knowledge, **I am NOT pregnant**

Signature Date Witness

2. **I may be pregnant at ths time**. I have been informed of the possible effects of radiation to a developing fetus and have consented to the x-ray examination(s) ordered by my physician.

Signature Date Witness

3. **I may be pregnant at this time. I do not wish to have an x-ray examination at this time.**

Signature Date Witness