

NEXT GENERATION RADIOLOGY
 560 Northern Blvd., Great Neck, NY 10021 516 504-1600
 4 Medical Drive, Port Jefferson, NY 11776 631 928-1600

This form must be completed in its entirety before your mammogram can be performed

Last Name _____	First Name _____	Date _____
Birth Date _____	Age _____	Referring Physician _____

HISTORY

Date of Last Mammogram: _____ Where Performed: _____ Date of Last Breast Exam: _____

Date of First Menses: _____ Last Menstrual Period: _____ Menopause Date: _____

Number of Children: _____ Age Had First Child _____ Are You Pregnant? YES _____ NO _____ Maybe _____

Did you ever Breast Feed? YES _____ NO _____ Have you Breast Fed With in Last 6 months? YES _____ NO _____

Have you gained/lost 20 lbs or more since your last mammogram? YES _____ Gained _____ lbs Lost _____ lbs
 NO _____ (No weight change or change of less than 20 lbs)

Are you of Ashkenazy Jewish Descent YES _____ NO _____

HAVE YOU USED ANY OF THE FOLLOWING:

	Yes	No	Date		Yes	No	
Oral Contraceptives	_____	_____	_____	Coffee or Tea?	_____	_____	Cups per Day _____
Estrogen	_____	_____	_____	Cigarettes?	_____	_____	Packs per Day _____
Progesterone	_____	_____	_____				

PERSONAL / FAMILY HISTORY OF BREAST/OVARIAN/UTERINE CANCERS (State Age When Diagnosed)

BREAST SURGERY HISTORY

	Right	Left	Date		Right	Left	Date
Cyst Aspiration	_____	_____	_____	Lumpectomy (Malignant)	_____	_____	_____
Sono Core Biopsy	_____	_____	_____	Mastectomy	_____	_____	_____
Stereotactic Biopsy	_____	_____	_____	Radiation (Date)	_____	Chemotherapy	_____
Surgical Biopsy (Benign)	_____	_____	_____	Implants or Reduction	_____	_____	_____

CURRENT SYMPTOMS

	Right	Left	Date	
Do you feel any Lumps?	_____	_____	_____	
Do you have Breast Pain?	_____	_____	_____	
Do you have Nipple Discharge?	_____	_____	_____	Color _____

Please mark the location of any lumps. If you have had any surgery, mark the area of the surgery, the year and the results on the diagram below:

