

Diagnostic Imaging Associates
100 College Parkway, Suite 185
Williamsville, NY 14221
(716) 636-1902
(716) 636-1367 Fax

Mammography Screening Sheet

Do you have any allergies to Latex? Yes No

Name: _____ Date: _____

DOB: _____ Ht. _____ Wt. _____

Have you ever been diagnosed with Breast Cancer? Yes No

Have any of your close blood relatives been diagnosed with Breast Cancer? Yes No

Family History of Breast Cancer:

Mother Age: _____ Sister Age: _____ Daughter Age: _____

Grandmother Age: _____ Other Relative: _____

Have you ever given birth? Yes No Age at birth of first child? _____

When was your last breast exam from your health care provider? _____

Previous Mammogram: Yes No If so, where and when? _____

Age at first menstrual period? _____ Have your menstrual periods stopped permanently? Yes No

Age when menstrual periods stopped? _____ Date when last menstrual period began? _____

Reason for Exam today: Screening Follow - Up Problem (Please Explain)

Are you currently experiencing any problems? (Please Specify)

Left Right Example: Lump, discharge, pain

Please explain: _____

Have you had any previous breast surgeries, including Augmentation, please explain?

Left Right Dates: _____

If you have had augmentation, what type are they? _____

Are they in-front of the muscle or behind the muscle? _____

Are you currently taking hormone replacements? Yes No

If yes, what are they? _____

Have you ever taken Oral Chemotherapy Agents? Yes No

What were they? _____

Our Radiologist may need to compare your prior mammogram studies, signing below will allow Diagnostic Imaging Associates the authorization to obtain those studies. Please sign below to give permission:

Patient Name: _____ Date: _____

Patient Signature: _____