SOLIS Mammography

Breast Imaging History Form

Patient Name_____

Patient DOB_____

Date of last mammogram: _____
Location of last mammogram? _____
Under what name: _____
Date of last menstrual period: _____

PLEASE SIGN BELOW TO DOCUMENT THAT YOU ARE NOT PREGNANT

Patient's Signature: _____ **Date:** _____

Current Symptoms: **L= left, R= right, B= both**

None: ☐

Lump: No ☐ Yes ☐ R L B When did you notice? _____
Describe: _____

Nipple Discharge: No ☐ Yes ☐ R L B What color? _____

Risk Factors:

Age at 1st menstrual period? _____
How many children have you delivered? _____ No children ☐
Your age when 1st child was born? _____
How many children did you breast feed? _____
Hysterectomy: No ☐ Yes ☐ When: _____ (age or year)
Ovaries Removed: No ☐ Yes ☐ When: _____ (age or year)
Hormone Use (estrogen, progesterone, Tamoxifen): No ☐ Yes ☐
Currently using birth control pills? No ☐ Yes ☐
Smoker? No ☐ Yes ☐ How many years? _____

Personal history of cancer:

Breast: No ☐ Yes ☐ **R L B** Age: _____
Ovarian: No ☐ Yes ☐ Age: _____
Other: No ☐ Yes ☐ Type: _____ Age: _____

Family history of cancer:

Aunt, grandmother, cousin – **Breast** No ☐ Yes ☐ **Ovarian** No ☐ Yes ☐
Mother, sister, daughter - **Breast** No ☐ Yes ☐ **Ovarian** No ☐ Yes ☐

Prior breast procedures: **L= left, R= right, B= both**
(Please indicate which breast & age of treatment)

Biopsy	_____ **R L B** Age___		Mastectomy	_____ **R L B** Age ____	
Implants	_____ **R L B** Age___		Lumpectomy	_____ **R L B** Age ____	
Reduction	_____ **R L B** Age___		Chemotherapy	____**R L B** Age ____	
Aspiration	_____ **R L B** Age___		Radiation	_____ **R L B** Age ____	

Technologist Signature: _____ Date: _____