OAKLAND MACOMB
BREAST IMAGING DIVISION

248-997-5805

Patient Name: ______________________ DOB: Age: ______

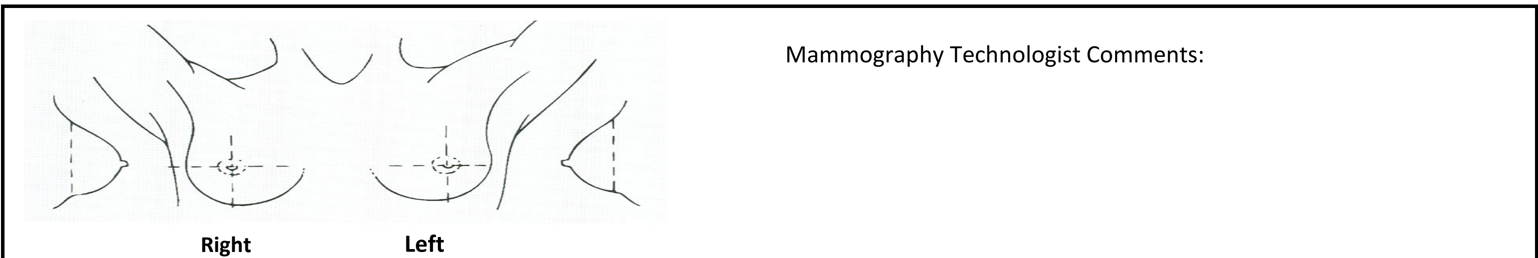
Primary Care Physician Name: ______________________ Phone # and Address: ______________________

Previous Mammogram ☐ Yes ☐ No If Yes, where/when Date:

Height/Weight: ______________________

- Are you having any unusual problems with your breasts? ☐ Yes ☐ No
  If yes, please circle: Right or Left Lump/Thickening Pain Nipple Discharge Enlarged Lymph Nodes Other
- Do you have a personal history of breast cancer? ☐ Yes ☐ No
  If yes, please circle: Right or Left Year Diagnosed: ________ Lumpectomy Mastectomy
- Do you have implants? ☐ Yes ☐ No ☐ Saline ☐ Silicone
- Have you had any breast procedures? ☐ Yes ☐ No
  If yes, please circle: Right or Left Biopsy Cyst Aspiration Reduction/Lift Year:
- Have you given birth to one or more children? ☐ Yes ☐ No Your Age at 1st birth: ________
- What was your age at the time of your first menstrual period? (approximate is fine) ________
- Last menstrual period: ________________
- Hormone Replacement Therapy (HRT) usage (current or previous)? ☐ Yes ☐ No Thyroid Medication ☐ Yes ☐ No
- Have you been tested for either BRCA1 or BRCA2 gene mutation? ☐ Yes ☐ No
  If yes, please circle: Tested/Normal BRCA1+ BRCA2+
- Have you been diagnosed with ovarian cancer? ☐ Yes ☐ No If yes, your age when diagnosed? ________
- Have any family members been diagnosed with BREAST or OVARIAN cancer? ☐ Yes ☐ No
- Have any family members been tested for BRCA gene mutation? ☐ Yes ☐ No
  If yes, please circle: Maternal/Paternal Grandmother Mother Sister Aunt Cousin Father Uncle Brother
- Have you been diagnosed with any form of arthritis? ☐ Yes ☐ No
  If yes, please circle: RA OA PA Lupus
- Do you have a pacemaker? ☐ Yes ☐ No
- Do you have an insulin pump? ☐ Yes ☐ No
- Any chance of pregnancy? ☐ Yes ☐ No
- Have you received previous radiation to chest for treatment of Hodgkin Lymphoma? ☐ Yes ☐ No
- Do you have any of the following on? Deodrant/Lotions/Powders ☐ Yes ☐ No
- Do you or have you ever smoked? ☐ Yes ☐ No

Patient Signature: ______________________ Date: ________



Mammography Technologist Comments: