GRC
Gurnee RADIOLOGY Centers

Bannockburn • Gurnee • Libertyville
(847) 599-1GRC

MAMMOGRAPHY PATIENT HISTORY FORM

Name_____

Referring Doctor_____

Phone Number (Day)_____ (Evening or Cell)_____

Menstrual Status: Age at 1st period?_____ Age at last period?_____

Are you pregnant?_____ Did you have a hysterectomy or ovaries removed?_____

Have you had a Mammogram before? Yes No

When?_____ Where?_____

Are you having Recent problems with your breasts? Yes No

Explain:_____

Are you taking any Hormones? Yes No

What kind & duration?_____

Have any of the following family members had breast cancer?

Mother_____ She was _____ years old when it was found?

Sister_____ She was _____ years old when it was found?

Daughter_____ She was _____ years old when it was found?

Males_____ He was _____ years old when it was found?

Have you ever had Breast Surgery? Yes No

Biopsy Right or left When?_____

Diagnosis_____

Reduction Right or left When?_____

Implants Right or left When & Type?_____

Have you ever had Breast Cancer? Yes No

Mastectomy When?_____ Diagnosis_____

Lumpectomy When?_____ Diagnosis_____

Radiation Therapy When?_____

Chemotherapy When?_____

Have you ever had any other cancers? Yes No

Type and When?_____

Have any of your female family members had cancer other than breast cancer? Yes No

Who?_____ What type?_____

By signing below, I acknowledge I have received and reviewed information regarding breast care.

It is very important that I have my previous mammograms available for comparison with my current exam as subtle changes may help detect breast cancer at an earlier stage. I understand it is my responsibility to provide prior examinations for comparison purposes.

Gurnee Radiology Center is required by the FDA to audit mammography outcomes. To help accomplish this, I give permission to give and receive medical information and mammography images to/from other physicians and medical facilities involved in my care.

I understand it is my responsibility to follow my referring doctor's advice concerning my follow-up breast care.

_____

Patient Signature Date

Mammographer_____

SYMPTOMS:

❑ None

❑ Lump How long has it been there?_____ ❑ RIGHT ❑ LEFT

❑ Pain (if focal) How Long?_____ ❑ RIGHT ❑ LEFT

❑ Retracted Nipple How Long?_____ ❑ RIGHT ❑ LEFT

❑ Nipple Discharge How Long?_____ Color_____ ❑ RIGHT ❑ LEFT

Occurs Spontaneously_____ Occurs When Expressed_____

Comments:_____

_____

_____

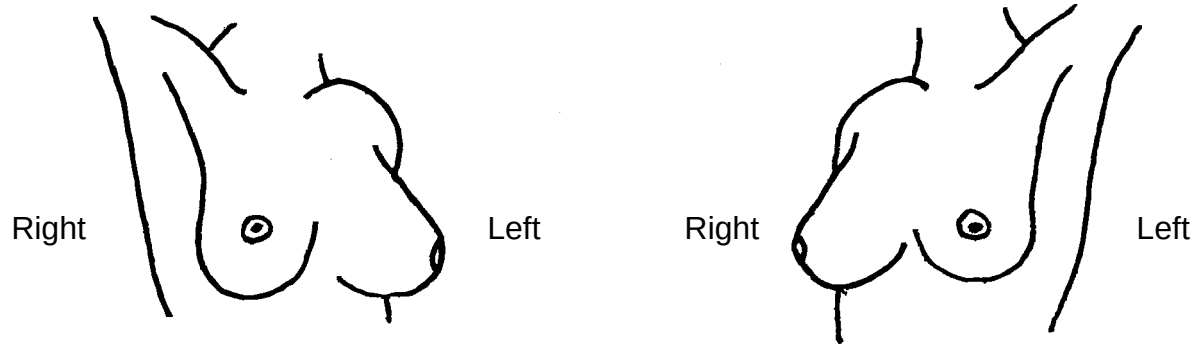
_____

_____

Patient told of possible additional studies ❑ Yes ❑ No

Patient tolerated procedure well ❑ Yes ❑ No

ILLUSTRATE: O = LUMP X = PAIN / = SCAR M = MOLE



Results given to patient

❑ Birads 1 or 2 ❑ 3 ❑ 4 ❑ 5

Follow up 6 months unilateral

12 months bilateral

Told by Technologist Radiologist

Radiologist signature_____

Old films requested:

_____

Fax # Date Initials