

GENERAL LEONARD WOOD ARMY COMMUNITY HOSPITAL

MAMMOGRAPHY WORKSHEET

Patient Name: _____ Age: _____ Sponsors SSN: _____ Date: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Indications: Baseline: _____ Annual: _____ Follow-up: _____ Lump: _____ Pain: _____ Discharge: _____ RT: _____ LT _____

Date of Last Mammogram: _____ Location: _____

Date of Last Physician Breast Exam: _____ Name of Physician: _____

1st Period Age: _____ Last Menstrual Cycle: _____ Menopause: Y/N _____ Age Began Menopause: _____

Age at 1st Pregnancy _____ Number of Pregnancies/Number of Live Births _____ / _____ **Pregnant: Y or N**

Are you taking Hormones? Y or N _____ Name of Hormone _____ How long? _____

If applicable what type of Birth Control do you use: _____

Family history (and age) of breast Cancer? mother _____ sister _____ daughter _____ other _____

Have you had breast Cancer? Y/N _____ RT or LT _____

If Yes, What treatment: _____ Lumpectomy _____ Mastectomy _____ Chemotherapy _____ Radiation _____ Trial _____

Have you ever had a breast Biopsy? Y/N _____ RT or LT _____

Do you have Breast Implants? Y/N _____

Have you ever had a cyst aspiration? Y/N _____ RT or LT _____

Year and Type of Implants: _____

Have you had a breast reduction? Y/N _____

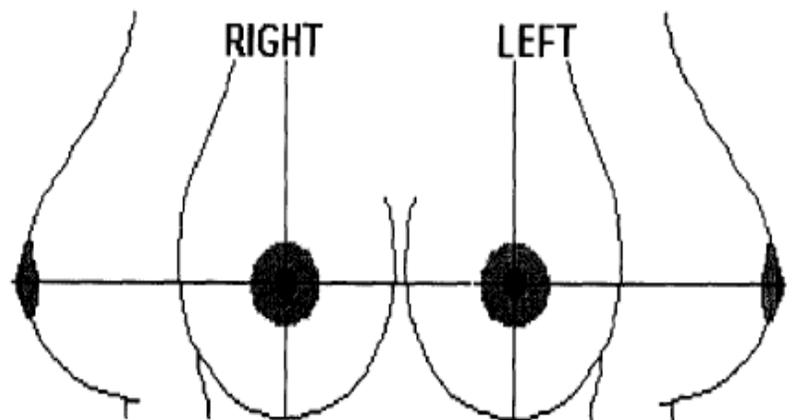
Implant Under Muscle or Over the Gland (Circle) _____

Technologist: _____

Comments: _____

Radiologist: _____

Comments: _____



I, _____, Hereby give authorization to GLWACH Radiology to contact me at the above phone number. I **ALSO** give my consent for the radiology staff members to identify themselves and or leave a message in the event I am unavailable with either an answering machine or a person answering the phone. Phone number to Call: **HOME WORK CELL**

SIGNATURE: _____