HENDERSON & WALTON
WOMEN'S CENTER, P.C.

Physician:

Office Location:

For Office Use Only

Mammography History

Today's Date: ______________________

Last Name: ______________________ First: ______________________ MI: ________

Street: ______________________ City: ______________________ State: ________

Zip: ______________ Birth date: ______________ Age: ____ SSN: ______________

Home Phone: ______________________ Office Phone: ______________________

Henderson & Walton Dr.: ______________________ Date of Visit: ______________________

Last Mammogram Exam: ______________ **Facility Name:** ______________________

Under what name? ______________ **Physician at that time?** ______________________

Date of Last Period ______________ **Last M.D. Breast Exam:** ______________________

- **Please sign below to document that you are not pregnant.**
- I authorize obtaining or releasing my breast health records for comparison and follow-up.

Patient's Signature: ______________________________ **Date:** ______________________

Reason for Today's Exam:

Routine Screening: ________ Baseline ________ Follow-up ________

Lump: No ______ Yes ______ When noticed? ______________________

Describe: ____

Nipple Discharge: No ______ Yes ______ Color? ______________________

History:

______ Personal history of breast cancer - Age ______

Hysterectomy: No ______ Yes ______ When: ______________________ *(Age or Year)*

Hormones: No ______ Yes ______ When: ______________________ *(Age or Year)*

Family History of Breast Cancer - ***check those that apply***

______ Aunt	______ Grandmother	______ Cousin
______ Mother	______ Sister	______ Daughter
______ Pre-menopausal	______ Post-menopausal	______

Prior Breast Procedures:

Please indicate year done & which breast.

Implants ______

Reduction ______

Biopsy (excisional) ______

Biopsy (needle) ______

Stereotactic Biopsy ______

Aspiration ______

If previous breast cancer:

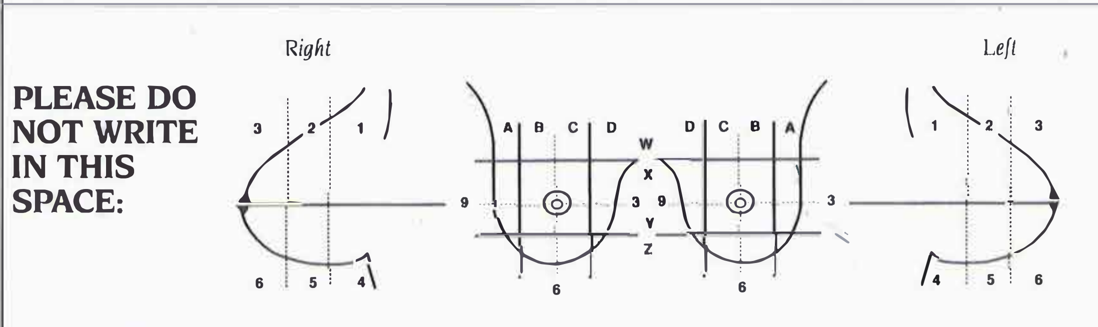
Mastectomy ______

Lumpectomy ______

Chemotherapy ______

Radiation ______

PLEASE DO NOT WRITE IN THIS SPACE:



Known Patient Data

Known Referring Doctor

Known Medical History

Known Risk Factors

Previous Procedures

Notes

Tech Initials: ______________

HWC058