Weill Cornell Imaging

NewYork-Presbyterian Weill Cornell Medicine

(office use)

Mammography History Sheet

Name: _____ Date of Exam: _____

Date of Birth: _____ Age: _____ Sex: _____ Height: _____ Weight: _____

1. **Do you have any new symptoms since your last breast imaging study, or current symptoms or changes of concern to you?** ☐ Yes ☐ No

   If yes, do you have any of the following? ☐Discharge ☐Lumps ☐Pain ☐Skin Changes ☐Other ☐None

   Please specify which breast: ☐ Right ☐ Left ☐ Bilateral

   When did these symptoms begin? _____

   If other, please specify (include date symptoms began) _____

2. **When was the last time a physician examined your breasts? (Month and Year)** _____

3. **Sex assigned at birth:**

   ☐ Female ☐ Male ☐ Unknown ☐ Not Recorded on Birth Certificate ☐ Choose Not to Disclose

   ☐ Gender non-confirming ☐ Uncertain ☐ Intersex

4. **What is your gender identity?**

   ☐ Female ☐ Male ☐ Transgender Female ☐ Transgender Male ☐ Other ☐ Choose Not to Disclose

   ☐ Gender non-confirming ☐ Something Else ☐ Nonbinary

5. **Any significant recent gain or loss of weight?** _____

6. **What is your ethnicity?** _____

7. **Is this your first mammogram?** ☐ Yes ☐ No

   If no and if outside of NYPH-Cornell-Columbia, when and where? _____

8. **Have you breast-fed since your last mammogram?** ☐ Yes ☐ No

   If yes, are you currently breast feeding? ☐ Yes ☐ No

9. **What is your gynecological history?**

   ☐ Premenopausal ☐ Perimenopausal *When was your last menstrual cycle?* _____

   ☐ Postmenopausal *Menopause at Age?* _____

   ☐ Other *Please specify* _____

10. **How old were you when you had your first period?** _____

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11. Please select all breast surgeries that you have had:

☐ Implants ☐ Lumpectomy for Cancer ☐ Mastectomy ☐ Reduction

☐ Excision (Surgical Removal non-cancerous lesion) ☐ Gender-Affirming Surgery/Chest contouring

☐ Other *(please specify)* _____ ☐ None

12. Have you previously had any of the following cancers?

☐ Breast ☐ Ovarian ☐ Other_____ ☐ None

Have you had treatment for breast cancer? ☐ Yes ☐ No

If yes, please select all that apply: ☐ Chemotherapy ☐ Radiation ☐ Surgery ☐ None

Please specify year of diagnosis: _____

13. Have you tested positive for any of the following cancer genes? Select all that apply:

☐ BRCA 1 ☐ BRCA 2 ☐ Positive for Other Mutation ☐ None

14. Any previous breast biopsies? ☐ Yes ☐ No

If yes, please specify which breast: ☐ Left ☐ Right ☐ Both breasts

15. Any family history of cancer? ☐ Yes ☐ No

If yes, any family history of breast or ovarian cancer? ☐ Yes ☐ No

If no, please specify outcome _____

Please complete this section only if your family member(s) had/have a history of breast or ovarian cancer.

Relation to patient: _____ ☐ Maternal ☐ Paternal

What type of cancer: _____ Age: _____

Genetically tested for: _____ Outcome: _____

Relation to patient: _____ ☐ Maternal ☐ Paternal

What type of cancer: _____ Age: _____

Genetically tested for: _____ Outcome: _____

Relation to patient: _____ ☐ Maternal ☐ Paternal

What type of cancer: _____ Age: _____

Genetically tested for: _____ Outcome: _____

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16. Previous chest radiation therapy unrelated to breast cancer at age: _____

17. Previous chemotherapy at age: _____

18. Are you currently taking hormones? Select all that apply:

☐ Estrogen ☐ Hormonal contraceptive ☐ Progesterone ☐ Raloxifene ☐ Tamoxifen
☐ Unspecified ☐ None

If you used or are currently using any of the hormones indicated above, please specify:
Age of First Use: _____ Age of Last Use: _____ Duration of Usage: _____ Intended Duration: _____

19. Is there any possibility that you are pregnant? ☐ Yes ☐ No

Patient:

_____

Please sign above

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