

Weill Cornell Imaging

New York-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

Please specify which breast: Right Left Bilateral

When did these symptoms begin? _____

If pain was selected, do you feel the pain in one specific spot or across a large area/all over the breast?

One spot All over

If other was selected, please specify (include when 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
 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

If other, please specify _____

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

- 6. Is this your first mammogram? Yes No**

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

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

If yes, are you currently breast feeding? Yes No

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8. What is your gynecological history?

- Premenopausal: *What was the first date of your last menstruation?* _____
- Perimenopausal: *What was the first date of your last menstruation?* _____
- Postmenopausal
- Other (*please specify*) _____

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

10. 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
- Needle biopsy (not subsequently removed with surgery)
- Other (*please specify*) _____ None

If any option was selected other than "None", please specify which breast:

- Left Right Both breasts

If "Excision" or "Needle Biopsy" was selected, please specify what was the result?

- Benign finding ADH ALH LCIS Other Unknown

If other, please specify _____

11. 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: _____

12. Have you tested **POSITIVE** for any of the following cancer genes? Select all that apply:

- BRCA 1 BRCA 2 Positive for Other Mutation Tested Negative Not Tested

13. Any biological family history of breast and/or ovarian cancer? Yes No Unknown

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

Relation to patient: _____ Maternal Paternal

What type of cancer: _____ At what age: _____

Tested positive for BRCA 1 or BRCA 2? Yes No

Relation to patient: _____ Maternal Paternal

What type of cancer: _____ At what age: _____

Tested positive for BRCA 1 or BRCA 2? Yes No

Relation to patient: _____ Maternal Paternal

What type of cancer: _____ At what age: _____

Tested positive for BRCA 1 or BRCA 2? Yes No

14. Have you had prior chest radiation therapy unrelated to breast cancer before age 30? Yes No

15. Are you currently taking hormone therapy or anti-hormone therapy? Yes No

If yes, please specify _____

Patient:

Please sign above