

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

Mammography History Sheet

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

Mammography History Sheet

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