BaylorScott&White
MEDICAL CENTER
LAKE POINTE
Joint ownership with physicians

Please indicate you notification preference: ______US Postal Mail or ______Email

MAMMOGRAPHY INFORMATION SHEET

Email address: ______________________________
(Please Print Legibly)

Last name:______________________ First: ______________________
Street address: ______________________ City: ______________ State: __________
Zip Code: ____________ Birth Date: ____________ Age: ________ Ethnicity: ______________
Home phone: ______________________ Cell/Other phone:______________________
Referring Physician: ______________________________

Personal Risk Factors, check/specify those that apply:

_______ Personal history of breast cancer – Age __________
_______ Personal history of ovarian or endometrial cancer – Age _________
_______ Personal history of other cancers______________________ – Age __________
_______ Previous chest radiation – Age __________

Family History of breast, ovarian, colon, or endometrial cancer, circle/specify those that apply:

_______ None that I am aware of
_______ Mother, Sister, Daughter______________ – Age __________ Maternal _____ Paternal _____
_______ Aunt, Grandmother, Cousin ______________ – Age __________ Maternal _____ Paternal _____
_______ Male Breast Cancer______________ – Age __________ Maternal _____ Paternal _____

Insert age where appropriate:

_______ Age at 1st menstruation _________ Age at Menopause
_______ Number of Live Births _________ Age of Hysterectomy
_______ Age of first full-term pregnancy _________ Ovaries Removed ______LT ______RT

Birth Control Pills Age of 1st use ___________ Age of Last used ____________
Estrogen Age of 1st use ___________ Age of Last used ____________
Progesterone Age of 1st use ___________ Age of Last used ____________
Tamoxifen Age of 1st use ___________ Age of Last used ____________

Prior breast procedures - please check where indicated, insert age & circle L=left, R=right, B=both

Biopsy _____R L B Cyst Aspiration _____R L B Ultrasound _____R L B
Lumpectomy _____R L B Mastectomy _____R L B Reduction _____R L B
Implants _____R L B ____Saline ____Silicone ____Pectoral Muscle ____Behind ____In Front

Symptoms/Reason for today's visit:

_______ None/Yearly Exam
_______ Lump How long has it been there? ______________________ R L B
_______ Pain How long? ______________________ R L B
_______ Nipple Discharge How long? ______________________ R L B
_______ Other (explain) How long? ______________________ R L B

LOCATION AND DATE OF LAST MAMMOGRAM: ______________________________
Patient Signature:______________________________ Today's Date: ______________

PLEASE DO NOT WRITE BELOW THIS LINE

Technologist signature:______________________________ 5 YR Risk Percentage______________