MNAP Medical Solutions

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Mammography Evaluation

If you had your previous mammogram at another facility you must bring films or CDs with you to the appointment.

Name	Date of Birth

Email

REASON FOR EXAM

☐ **Baseline** (check only if you have not had previous mammograms)

☐ **Routine/yearly study**

Approximate date of previous study _____

At what facility was it performed? _____

☐ **Followup**

Approximate date of previous study _____

At what facility was it performed? _____

HEALTH HISTORY

1. **Are you pregnant?**
   ☐ Yes ☐ No
2. **Do you still have a menstrual period every month?**
   ☐ Yes ☐ No
3. **Date of last menstrual period?**
4. **Have you had a hysterectomy?**
   ☐ Yes ☐ No Date
5. **Have you breastfed within the past three months?**
   ☐ Yes ☐ No
6. **Have you ever had trauma to your breast that caused black and blue marks?**
   ☐ Yes ☐ No
7. **Have you ever had any type of cancer?**
   ☐ Yes ☐ No
   If yes, please explain
8. **Are you on chemotherapy?**
   ☐ Yes ☐ No
9. **Are you taking birth control pills or any type of hormone?**
   ☐ Yes ☐ No
   If yes, when did you start taking hormones?
   Month _____ Year _____
   Name of hormone

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RISK FACTORS

1. **Have you had breast cancer?**
   ☐ Yes ☐ No

2. **I was over 29 years old when I had my first child**
   ☐ Yes ☐ No

3. **Did you natural mother, sisters or daughters ever have breast cancer?**
   ☐ Yes ☐ No
   If yes, Pre or postmenopausal _____
   Age at diagnosis

SYMPTOMS AND HISTORY

1. **Have you or your doctor felt a lump?**
   ☐ Yes ☐ No
   Which breast and for how long?

2. **Do you have inverted nipples?**
   ☐ Yes ☐ No
   Which breast and for how long?

3. **Do you have pain or tenderness?**
   ☐ Yes ☐ No
   Which breast and for how long?

4. **Do you have nipple discharge?**
   ☐ Yes ☐ No
   Which breast and for how long?

5. **Any other symptoms?**
   ☐ Yes ☐ No
   Please explain

6. **Previous breast surgery?**
   ☐ Yes ☐ No
   Which breast and approximate date?

7. **Radiation treatments to your breasts?**
   ☐ Yes ☐ No
   Which breast and approximate date?

8. **Do you have breast implants?**
   ☐ Yes ☐ No
   Silicone or saline?

9. **Previous breast aspirations of a cyst?**
   ☐ Yes ☐ No
   Which breast and approximate date?

10. **Have you ever had cancer of the uterus (womb)**
    ☐ Yes ☐ No

MNAP Medical Solutions requests your authorization to obtain your previous medical mammographic records and/or future outcome data pertaining to this examination.

Please send my reports to Doctor(s)

Patient Signature	**Date**
Technologist Signature	**Date**