Valley Medical Group
Valley Health System

Today's Date: _____ MRN_____

PATIENT VISIT/MEDICAL HISTORY – MAMMOGRAPHY

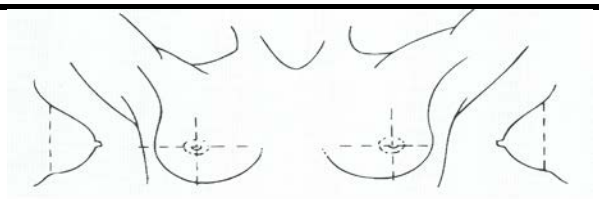
Patient Name: _____ Date of Birth: _____

CHIEF COMPLAINT

_____

_____

_____



PERSONAL HISTORY

☐ Ashkenazi	☐ BRCA1 or 2 Positive	☐ History of Breast Cancer

Implanted device/pace maker? ☐ Yes ☐ No If so, type:_____

Significant weight loss since last visit: ☐ Yes ☐ No

Any current illness/infection: ☐ Yes ☐ No Explain:_____

Other significant medical history:_____

SURGICAL HISTORY (Please check previous surgeries that you have had, including date)

Procedure	Date of Surgery	Procedure	Date of Surgery
☐ Breast Biopsy		☐ Removal of ovary (Oophorectomy)	
☐ Breast Surgery		☐ Removal of ovarian cyst (Cystectomy)	
☐ Total Abdominal Hysterectomy		☐ Other	

GYN HISTORY

Any possibility of pregnancy: ☐ Yes ☐ No Date of last menstrual cycle:_____

Age at First Child: _____ Age at Menarche: _____ If Post Menopausal, Age at Menopause: _____

Length of use:_____ ☐ Estrogen ☐ Progesterone ☐ Tamoxifen ☐ Raloxifene

Breast Implants: ☐ Yes ☐ No ☐ Silicone gel ☐ Saline

Date of Most Recent Mammogram: _____

Condition	Relation (Mother, Sister, Daughter, Maternal Grandmother/Aunt, Paternal Grandmother/Aunt)	Age when Diagnosed
☐ Malignant Neoplasm of Uterus (Uterine Cancer)		
☐ Malignant Tumor of Breast (Breast Cancer)		
☐ Malignant Tumor of Cervix (Cervical Cancer)		
☐ Malignant Tumor of Ovary (Ovarian Cancer)		