Delaney # ________________

DELANEY RADIOLOGISTS
BREAST IMAGING HISTORY FORM

Patient Name: ______________________ Referring Physician: ______________________

Date of Birth: ______________________ Age: ______________________

Phone #: ______________________ Alternate Phone #: ______________________

Last mammogram performed at ❑ Delaney ❑ Other Facility: Name ________________ Year________

Date of your last menstrual period: ______________________

Is there any possibility you could be pregnant? .... ❑ Yes ❑ No

Are you on hormones? .... ❑ Yes ❑ No

Have you personally had cancer of the breast? .... ❑ Yes ❑ No

If yes, which breast?________________When? ________________

Have you ever had any breast surgery? .... ❑ Yes ❑ No

If yes, what type of surgery?

❑ Implants	Date(s) of Surgery ________________	
❑ Reduction	Date(s) of Surgery ________________	
❑ Cyst Aspiration	Date(s) of Surgery ________________	Right or Left ________________
❑ Biopsy	Date(s) of Surgery ________________	Right or Left ________________
❑ Lumpectomy	Date(s) of Surgery ________________	Right or Left ________________
❑ Mastectomy	Date(s) of Surgery ________________	Right or Left ________________
❑ Reconstruction	Date(s) of Surgery ________________	Right or Left ________________

ARE YOU HAVING ANY NEW PROBLEMS WITH YOUR BREASTS TODAY? .... ❑ Yes ❑ No

If yes, please explain ______________________

(If you have any current symptoms or if your physician is following up on any prior finding, your mammogram will be coded as diagnostic rather than screening.)

Patient's Signature ______________________ Date: ______________________

FOR TECHNOLOGIST USE ONLY

Notes: ______________________

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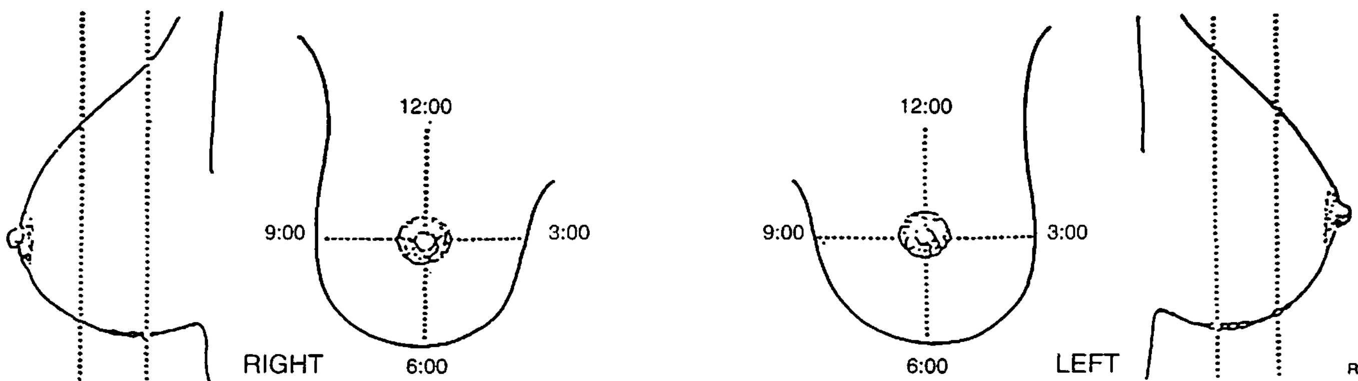
______________________ : ________________
Technologist



REV 7/09