

ARLENE WEINSHELBAUM, M.D., P.A.
Mammography History Sheet

Appointment Date: _____

Name _____ Date of Birth _____ Age _____

Address _____
(street) (city) (zip code)

Your Employer _____ Business Telephone _____

Social Security Number _____ Home Phone _____

Email Address _____

Spouse's Name _____ Married _____ Single _____ Divorced _____ Widow _____

Please list the doctors you want a report to go to: _____

Medical Information

Have you ever had a mammogram before? Yes No

If so, where and when? _____

Do you have any breast pain? _____ When? _____ Which breast? _____

Do you have any breast cysts? _____ When? _____

Is your nipple inverted? _____ Which breast? _____

Do you have any nipple discharge? _____ Which breast? _____

Does it come out by itself (without any pressure)? _____

Do you have a lump or thickening? _____

If so when did you first notice it? _____ Which breast? _____

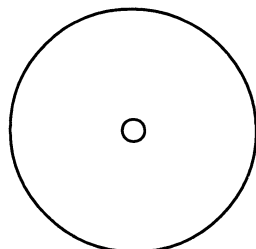
Have you or any of your blood relatives ever had BREAST cancer? _____

If so, what relationship? _____ At what age? _____

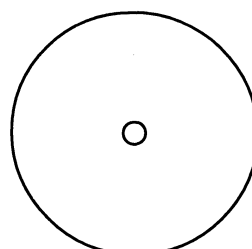
Are you taking any hormones? Yes No

Do you have breast implants? Yes No

If you have ever had breast surgery, please mark the area of surgery and year on the diagram.



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