Facility:

Colorado Mammography Project

History Form
Version 1.9 12/18/02

SSN#: _ _ _ - _ _ - _ _ _ _ **Medical Record ID:** _____

Date of Birth: _ _ / _ _ / _ _ **Date of Study:** _ _ / _ _ / _ _

Last Name: _____

First Name: _____ **M.I.:** _____ **Maiden:** _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Daytime Phone: (_ _ _) _ _ _ - _ _ _ _ **County:** _____

Referring Physician: _____

Address: _____

Daytime Phone: (_ _ _) _ _ _ - _ _ _ _ **County:** _____

Of Hispanic Origin? ❑ Yes ❑ No ❑ Not Sure

Ethnic Group:
- ❑ Black
- ❑ White
- ❑ Asian/Pacific Islander
- ❑ Native American/Aleutian/Eskimo
- ❑ Other
- ❑ Not Sure

Last Year of Schooling:
- ❑ less than high school
- ❑ high school graduate/ GED
- ❑ some college/tech school
- ❑ college/post-college graduate

Previous mammogram? ❑ No ❑ Yes Date: _ _ / _ _ / _ _ Facility & Location: _____

Has your mother had breast cancer? ❑ Yes at age _____ ❑ No ❑ Don't know

Has your sister(s) had breast cancer? ❑ Yes at age _____ ❑ No ❑ Don't know

Has your daughter(s) had breast cancer? ❑ Yes at age _____ ❑ No ❑ Don't know

Have you had breast cancer? ❑ Right breast ❑ Left breast ❑ Both breasts at age _____ ❑ No

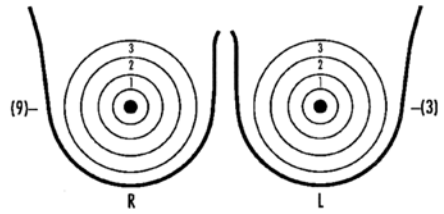
Have you had a breast procedure before? ❑ No ❑ Yes (If yes, check all that apply)

	RIGHT	LEFT	BOTH	RIGHT DATE	LEFT DATE
Surgical Biopsy	❑	❑	❑	_ _ / _ _ / _ _	_ _ / _ _ / _ _
Needle Biopsy	❑	❑	❑	_ _ / _ _ / _ _	_ _ / _ _ / _ _
Mastectomy	❑	❑	❑	_ _ / _ _ / _ _	_ _ / _ _ / _ _
Lumpectomy	❑	❑	❑	_ _ / _ _ / _ _	_ _ / _ _ / _ _
Radiation Therapy	❑	❑	❑	_ _ / _ _ / _ _	_ _ / _ _ / _ _
Implants	❑	❑	❑	_ _ / _ _ / _ _	_ _ / _ _ / _ _
Chemotherapy	❑	❑	❑	_ _ / _ _ / _ _	_ _ / _ _ / _ _
Breast Reduction	❑	❑	❑	_ _ / _ _ / _ _	_ _ / _ _ / _ _
Breast Reconstruction	❑	❑	❑	_ _ / _ _ / _ _	_ _ / _ _ / _ _
Don't know the type	❑	❑	❑	_ _ / _ _ / _ _	_ _ / _ _ / _ _
Other	❑	❑	❑	_ _ / _ _ / _ _	_ _ / _ _ / _ _

Have you had breast problems in the last 3 months? ❑ No ❑ Yes ❑ Don't know

IF YES: A) Indicate for each breast:

	RIGHT	LEFT	BOTH
Lump	❑	❑	❑
Discharge	❑	❑	❑
Other	❑	❑	❑ Other: _____
Pain	❑	❑	❑



Did you make your appointment today because of these problems? ❑ No ❑ Yes

Current Height ft _____ in _____ Current Weight _____

Are you presently taking hormone medication? ❑ No ❑ Yes ❑ Don't know Year started? _____

Type of hormone medication (check one) ❑ hormone replacement ❑ natural/herbal ❑ oral contraceptives ❑ tamoxifen ❑ raloxifene ❑ other

Have you had a hysterectomy? ❑ No ❑ Yes ❑ Don't know If yes, date? _ _ / _ _ / _ _

Have both of your ovaries been removed? ❑ No ❑ Yes ❑ Don't know

When was your last natural menstrual period (natural refers to the last period prior to menopause)? _ _ / _ _ / _ _

Have your periods stopped? ❑ No ❑ Yes

Is your insurance paying for this visit? ❑ Yes ❑ No (check all that apply) ❑ No Insurance ❑ Medicare ❑ Medicaid ❑ HMO ❑ Other