DR. ADAM G. CROUCH, INC., DBA
DIAGNOSTIC MEDICAL X-RAY AND IMAGING
MAMMOGRAM OR BREAST MRI HISTORY SHEET

NAME: _____ DATE OF BIRTH: _____ TODAY'S DATE: _____

REFERRING PHYSICIAN: _____

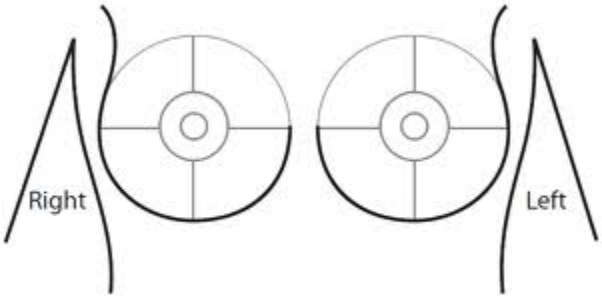
Do you feel a lump? _____ Yes No Rt Lt
Any localized pain, soreness, or discomfort? _____ Yes No Rt Lt
Nipple discharge? _____ Yes No Rt Lt
Inverted nipple?_____ Yes No Rt Lt
Are any of the above a **NEW** finding? _____ Yes No

History of previous breast cancer? _____ Yes No Rt Lt
Do you have breast implants? _____ Yes No Rt Lt
What type? _____
Fibrocystic breasts? _____ Yes No
Have you had any injury to either breast? _____ Yes No Rt Lt
Any previous breast surgery? _____ Yes No Rt Lt
When? _____ What type? _____

Is there a family history of breast cancer? _____ Yes No
Which relative? _____ (Grandmother, mother, daughter, sister, aunt)
Please check one that applies Periods _____ Menopause _____ Hysterectomy _____
Age of first period _____ Age of menopause/hysterectomy _____
Do you take hormones? _____ Yes No
What type? Birth control ____ estrogen _____ thyroid _____ progesterone _____ other _____
Number of pregnancies _____
Did you breast feed? _____ Yes No
Do you practice breast self-examination? _____ Yes No
Previous mammogram _____ Yes No
When? _____ Where? _____

OFFICE USE ONLY

Indicate problem area



Tolerated procedure: Well _____ moderately well _____ poorly _____