

**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

RIGHT

LEFT

Tolerated procedure: Well _____ moderately well _____ poorly _____