

SOLIS WOMEN'S HEALTH MAMMOGRAPHY WORKSHEET

PATIENT TO COMPLETE

Last _____ First _____ MI _____ DOB _____ Date of Exam _____

Referring physician _____ Patient Signature _____

Date of last mammogram _____ Location _____ Date of last breast exam by a physician _____

Are you currently pregnant or trying to conceive? Yes No Number of live births _____ Age at 1st Pregnancy _____

Are you breast feeding? Yes No Date/age of Last period. _____ Hysterectomy Yes No Ovaries removed Yes No

Age Menstruation Began _____ Age Menopause _____

Do you have any new breast problems?

No

- or -

- | | | |
|--|--------------------------------|-------------------------------|
| <input type="checkbox"/> Lump | <input type="checkbox"/> Right | <input type="checkbox"/> Left |
| <input type="checkbox"/> Pain | <input type="checkbox"/> Right | <input type="checkbox"/> Left |
| <input type="checkbox"/> Nipple discharge | <input type="checkbox"/> Right | <input type="checkbox"/> Left |
| <input type="checkbox"/> Trauma | <input type="checkbox"/> Right | <input type="checkbox"/> Left |
| <input type="checkbox"/> Other – please describe _____ | | |

Have you had any of the following?

No

- or -

- | | | | | |
|--|--------------------------------------|-------------------|-------------------------------|------------|
| <input type="checkbox"/> Reduction | <input type="checkbox"/> Right | Year _____ | <input type="checkbox"/> Left | Year _____ |
| <input type="checkbox"/> Cyst drained | <input type="checkbox"/> Right | Year _____ | <input type="checkbox"/> Left | Year _____ |
| <input type="checkbox"/> Surgical Biopsy | <input type="checkbox"/> Right | Year _____ | <input type="checkbox"/> Left | Year _____ |
| <input type="checkbox"/> Needle-core biopsy | <input type="checkbox"/> Right | Year _____ | <input type="checkbox"/> Left | Year _____ |
| <input type="checkbox"/> Lumpectomy for breast cancer | <input type="checkbox"/> Right | Year _____ | <input type="checkbox"/> Left | Year _____ |
| <input type="checkbox"/> Radiation for breast cancer | <input type="checkbox"/> Right | Year _____ | <input type="checkbox"/> Left | Year _____ |
| <input type="checkbox"/> Mastectomy for breast cancer | <input type="checkbox"/> Right | Year _____ | <input type="checkbox"/> Left | Year _____ |
| <input type="checkbox"/> Chemo for breast cancer | | | | |
| <input type="checkbox"/> Implants | <input type="checkbox"/> Right | Year _____ | <input type="checkbox"/> Left | Year _____ |
| Have they been replaced? <input type="checkbox"/> N <input type="checkbox"/> Y | | If yes Date _____ | | |
| Type <input type="checkbox"/> Silicone <input type="checkbox"/> Saline <input type="checkbox"/> Dual | <input type="checkbox"/> Other _____ | | | |
| Location <input type="checkbox"/> Subglandular (Under skin) | | | | |
| <input type="checkbox"/> Subpectoral (Under muscle) | | | | |

Are you currently taking hormones for birth control or menopause?

No

- or -

- Yes. Date started _____ Date stopped _____
Type _____

Have you or any member of your family had a history of breast cancer?

No

- or -

- | | | | |
|---|------------------------|--|--|
| <input type="checkbox"/> Self | Age at diagnosis _____ | | |
| <input type="checkbox"/> Mother | Age at diagnosis _____ | | |
| <input type="checkbox"/> Sister | Age at diagnosis _____ | | |
| <input type="checkbox"/> Daughter | Age at diagnosis _____ | | |
| <input type="checkbox"/> Grandmother | Age at diagnosis _____ | <input type="checkbox"/> Mother's side | <input type="checkbox"/> Father's side |
| <input type="checkbox"/> Aunt | Age at diagnosis _____ | <input type="checkbox"/> Mother's side | <input type="checkbox"/> Father's side |
| <input type="checkbox"/> Other family members | Age at diagnosis _____ | <input type="checkbox"/> Mother's side | <input type="checkbox"/> Father's side |

Check if you or a family member have had cancer.

No

- or -

- | | | | |
|-----------------------------------|------------------------|------------|---------------------|
| <input type="checkbox"/> Ovaries | Age at diagnosis _____ | Self _____ | Family Member _____ |
| <input type="checkbox"/> Colon | Age at diagnosis _____ | Self _____ | Family Member _____ |
| <input type="checkbox"/> Prostate | Age at diagnosis _____ | Self _____ | Family Member _____ |
| <input type="checkbox"/> Other | Age at diagnosis _____ | Type _____ | |

FOR CLINICAL USE

Technologist comments: _____

_____ Initials _____

Radiologist Comments: _____

Findings

- Almost entirely fatty Scattered fibroglandular Heterogeneously dense Extremely dense

