

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

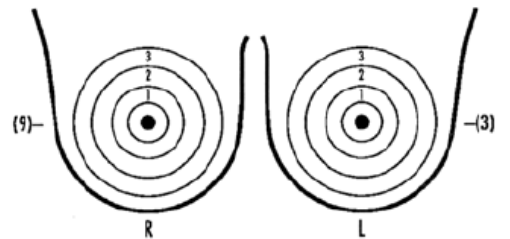
Have you had a breast procedure before? No Yes (If yes, check all that apply)

	RIGHT	LEFT	BOTH	RIGHT DATE	LEFT DATE
Surgical Biopsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___ / ___ / ___	___ / ___ / ___
Needle Biopsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___ / ___ / ___	___ / ___ / ___
Mastectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___ / ___ / ___	___ / ___ / ___
Lumpectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___ / ___ / ___	___ / ___ / ___
Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___ / ___ / ___	___ / ___ / ___
Implants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___ / ___ / ___	___ / ___ / ___
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___ / ___ / ___	___ / ___ / ___
Breast Reduction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___ / ___ / ___	___ / ___ / ___
Breast Reconstruction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___ / ___ / ___	___ / ___ / ___
Don't know the type	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___ / ___ / ___	___ / ___ / ___
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___ / ___ / ___	___ / ___ / ___

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	Other: _____
Lump	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	



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 you periods stopped? No Yes

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