CAROLINA MAMMOGRAPHY REGISTRY

SIDE A

Social Security Number _____

Chart Number _____

Date of Birth _____

Study Date _____

Gender: ☐ Female ☐ Male

Last Name _____

First Name _____

Middle Init. _____Maiden Name_____

Street Address: _____

Street Address: _____

City _____ _____ County _____

State _____ Zip Code _____

Phone Number (____) _____

Check ✓ **all** that apply to your racial/ethnic identity:

☐ Black ☐ Hispanic/ Latin
☐ White ☐ Other _____
☐ Asian
☐ American Indian: What tribe? _____

What is the highest level of education you have completed?(✓)

☐ Less than high school
☐ High school/GED
☐ Some college
☐ College grad. or post college grad.

Have you had a previous mammogram?

☐ Yes ☐ No ☐ Don't know

If *yes*, the date: _____

Was it done at ☐ this facility or ☐ at another facility?

Please name the facility if not here _____

Have you been diagnosed with breast cancer?

☐ No
☐ Yes, ☐ Left ☐ Right ☐ Both

What month and year were you first diagnosed? _____

Has your mother, sister, or daughter had breast cancer?
Check ✓ all that apply.

Mother: ☐No ☐Yes At age: _____

Sister: ☐No ☐Yes At age: _____

Daughter: ☐No ☐Yes At age: _____

Have you had previous breast biopsies or surgery?
If *yes*, please ✓ the chart below and include **date(s) of the procedures**.

	Left ✓	Left date*	Right ✓	Right date*
Cyst Aspiration				
Surgical Biopsy				
Needle Biopsy				
Mastectomy				
Lumpectomy				
Radiation Therapy				
Breast Implants				
Chemotherapy				
Reduction				
Reconstruction				
Other				

Have you had breast problems in the past 3 months?

☐ Yes ☐ No

If *yes*, please fill in the chart with a ✓ below:

	Left	Right	Both	Comments
Lump				
Discharge				
Other				
Pain				

Did you make this appt. as a result of these problems?

☐ Yes ☐ No

What is your current height? Ft/inches _____
What is your current weight? Lbs. _____

Are you currently taking hormones?

☐ Yes, year you began _____ ☐ No
☐ Don't Know

Please ✓ the hormone you take:

☐ Tamoxifen/ Raloxifene ☐ Oral Contraceptives
☐ Hormone replacement ☐ Other
☐ Natural/Herbal ☐ Don't Know

Have you had Hysterectomy surgery? ☐ Yes ☐ No

If *yes*, when (date)? _____

Have your ovaries been removed?

☐ Yes, how many? _____
☐ No ☐ Don't know

Have your regular periods stopped?

☐ No, my last menstrual period began _____
☐ Yes, they stopped naturally
☐ Yes, but have them now from taking hormones
☐ Yes, they stopped after surgery
☐ Not sure, they are less frequent

Is your insurance paying for **this** visit?

☐ Yes
☐ No, I am paying for this visit out of my own funds
☐ Don't know

If *yes*, please ✓ which insurance:

☐ Medicare ☐ other _____
☐ Medicaid ☐ BCCCP
☐ HMO or health plan ☐ Private

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