



...Where Patients Come *FIRST*

(716) 631-2500

MAMMOGRAPHY SCREENING

Do you have a latex sensitivity or allergy? YES NO

Have you had a breast exam from your doctor (OB/GYN, GP, etc.) within the last year?

Yes When: _____

No

NAME: _____ DATE OF BIRTH: _____
Please Print

Have you had a previous mammogram?

YES NO

Date: _____ Name of Facility: _____

Are you currently taking hormones? (ex.: HRT, Birth Control, or Thyroid meds)

YES: For how long _____ NO

Have you had any breast surgery?

YES What: _____ When: _____ Which Breast: _____ NO

Please circle the type of mammogram you are here for today:

ROUTINE / FOLLOW-UP / PROBLEM: Explain _____

Do you have any immediate family history of breast cancer?

YES Who: Mother Sister Daughter Age of Diagnosis _____

NO

Do YOU have any personal history of cancer?

Ovarian Cancer Lung Cancer Breast Cancer

Skin Cancer Other: _____

Was your first child born after age 30?

YES NO

Occasionally the Radiologist has a need to compare previous films to the studies you are having today, and a signed authorization is required to obtain these.

Please sign below giving permission for previous films to be released to Windsong Radiology Group, P.C.: 55 Spindrift Drive, Williamsville, NY 14221.

Patient's Signature: _____ Date: _____