MALE MAMMOGRAPHY HISTORY

Name: _____ Age:_____ Date:_____

Referring Doctor: _____ Imaging Center:_____

Reason for this examination:_____

Have you had a Mammogram/Ultrasound before? ☐Yes ☐No When?_____ Where?_____

Have you ever had a Breast MRI before? ☐Yes ☐No When?_____ Where?_____

PHYSICAL CONCERNS		**Right**	**Left**	**How Long?**
Do you feel a lump or mass?	☐Yes ☐No			
Redness, pain or swelling	☐Yes ☐No			
Additional Information:				
Previous Breast Cancer	☐Yes ☐No			
Additional Information:				

GENERAL HISTORY

Any family history of breast cancer? ☐Yes ☐No

Are you currently taking or have taken steroids within the last 12 months? _____

Have you had any other type of cancer? ☐Yes ☐No

If yes, what kind?_____ For how long? _____

Please list any medication that you are taking or may have taken at time when your problem was first noticed:

_____

OFFICE USE ONLY:

Clinical indications/Notes: _____

_____

_____

_____

Technologist's Name:_____

1. On review of your mammogram, if an area needs further evaluation, we will contact you to schedule an appointment. (There is an additional charge for these views).
2. If an ultrasound examination is recommended, this is considered a separate study and separate charge.

PLEASE BE ADVISED THAT A DIAGNOSTIC MAMMOGRAM AND/OR BREAST ULTRASOUND ARE NOT CONSIDERED TO BE A ROUTINE PREVENTATIVE EXAM AND MAY INCUR ADDITIONAL OUT OF POCKET EXPENSE.

To the best of my knowledge, all of the above is true and correct.

Patient Signature: _____ Date: _____ / _____ / _____