Pink Ribbon Mammography
At the Woman's Clinic
244 Coatsland Drive
Jackson TN 38301
731-422-4642

Indicate Changes since last mammogram with us or Complete in full if first visit with us

Name:	Date of Birth:	Age:	Phone (H):
Address:	City:	State:	Phone (W):

1. Number of births: _____
2. Age Started Period _____
3. Age when FIRST child born? _____
4. Date of Last Period? _____
5. Age at Menopause? _____
6. Age Uterus (womb) removed? _____
7. Age Ovaries Removed? _____ Both _____ Right _____ Left _____

---

8. Previous Mammogram? Yes No Year: _____
   Location of last mammogram, if not here: _____
   If your name was different at that time, please note: _____
9. Breast Cancer Yes No Both Right Left When? _____
10. Radiation Therapy to breast? Yes No Both Right Left When? _____
11. Chemotherapy Yes No
12. Diagnosed with any cancer? Yes No
13. Have you had any of the following surgery/procedures on your breast?
    - Mastectomy Yes No Both Right Left When? _____
    - Lumpectomy Yes No Both Right Left When? _____
    - Excisional Biopsy Yes No Both Right Left When? _____
    - Needle Biopsy Yes No Both Right Left When? _____
    - Cyst Aspiration Yes No Both Right Left When? _____
    - Reduction Yes No Both Right Left When? _____
    - Implants Yes No Both Right Left When? _____
14. Have you ever taken the following?
    - Birth Control Pills Yes No Age Started _____ Age Stopped _____ Total Years _____
    - Estrogen Yes No Age Started _____ Age Stopped _____ Total Years _____
    - Progesterone Yes No Age Started _____ Age Stopped _____ Total Years _____
    - Tamoxifen Yes No Age Started _____ Age Stopped _____ Total Years _____
15. Have NEW symptoms developed since your last mammogram? How Long?
    - Lump/Mass/Thickening Yes No Both Right Left _____
    - Bloody Nipple Discharge Yes No Both Right Left _____
    - Non bloody Nipple Discharge Yes No Both Right Left _____
    - New Nipple Retraction/Abnormalities Yes No Both Right Left _____
    - Implant changes/abnormalities Yes No Both Right Left _____
    - New Breast Pain (not related to cycle) Yes No Both Right Left _____
16. Family Members who had breast cancer?
    - Mother/Father Yes No Age Diagnosed _____
    - Sister/Daughter Yes No Age Diagnosed _____
    - Grandmother/Aunt Yes No Age Diagnosed _____
17. Would you like information about BSE (Breast Self Exam)? Yes No

---

I authorize the release of any Medical Record information (including mammogram films/reports) necessary to the Woman's Clinic, PA 244 Coatsland Drive, Jackson, TN 38301 FAX 731-422-2277

Patient or Authorized Person Signature