

CONNECTICUT VALLEY RADIOLOGY, PC

GERARD C. BUFFO, M.D., F.A.C.R.

BRADLEY H. STAEHLE, M.D.

LORI B. GOMEZ, D.O.

Name: _____ DOB: _____ Today's Date: _____

Referring M.D.: _____

1. Have you had a mammogram before? Y N Where & When: _____

2. Is this mammogram routine? Y N If no, why? _____

3. Is there a history of breast cancer in your family? Y N

IF YES: WHO AND AT WHAT AGE WAS IT FOUND?

MYSELF _____ MOTHER _____ SISTER _____ DAUGHTER _____ OTHER _____

4. Have you had a child? Y N Your age when you had your 1st born? _____

5. Do you have, or have you used hormones: (Estrogen, Premarin) Y N

WHICH TYPE? _____ HOW LONG? _____ STILL USING? _____

6. Have you breast fed within the past 3 months? Y N

7. Have you had a weight change of more than 10 pounds in the past year? Y N LOST or GAINED

8. Have you ever had trauma to your breast to cause black & blue marks? Y N

9. Breast Implants? Y N

NOTE: If there is deodorant or powder on your breast or on your underarms, please wash it off before you have your mammogram. Ask the technologist for help if you need it.*

FOR THE TECHNOLOGIST TO COMPLETE

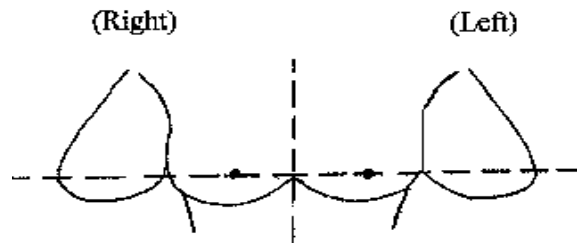
Pregnant? Y N

Check: Breast Surface (Including Medial, Inferior)
 Nipples: Inverted? Y N
 Discharge? Y N How long? _____

Breast Size Discrepancy? Y N
 Last Clinical Breast Exam? _____

History of prior breast surgery or aspiration _____

Technologist: _____



- MOLE
- ✱ LUMP
- ## SCAR
- Δ FOCAL
- ◇ PAIN