Check in Time_____

**MAGAN MEDICAL CLINIC**
**DEPARTMENT OF RADIOLOGY**
420 W. Rowland St., Covina, CA 91723
(626) 331-6411

Panel # _____

Name _____Today's Date _____/_____/____Age _____Ordering Dr._____
Reason for Exam LUMP_____PAIN_____ANNUAL EXAM_____
Last Mammogram Date_____/_____/_____ Where_____

**Have You Ever Had:**

| | | | | | |
|---|---|---|---|---|---|
| A. Breast Cancer | No | Yes | If Yes, When_____ | Right | Left |
| B. Mastectomy | No | Yes | If Yes, When_____ | Right | Left |
| C. Lumpectomy | No | Yes | If Yes, When_____ | Right | Left |
| D. Radiation or Chemotherapy | No | Yes | If Yes, When_____ | Right | Left |
| E. Biopsy of Breast | No | Yes | If Yes, When_____ | Right | Left |
| F. Needle Aspiration | No | Yes | If Yes, When_____ | Right | Left |
| G. Nipple Discharge | No | Yes | If Yes, When_____ | Right | Left |
| H. Injury To Breast | No | Yes | If Yes, When_____ | Right | Left |
| I. Implants or Breast Reduction | No | Yes | If Yes, When_____ | Right | Left |

Has your mother, sister or daughter ever been diagnosed with breast cancer? No Yes At what age? ____

Have you had any children? No Yes If Yes, were you over 27 years old at birth of first child? No Yes
Did you breast feed? No Yes

Are you presently taking hormones? No Yes If Yes, for how long? _____

Date of last menstrual period, If still menstruating_____ If not, when did menses cease? _____

Any significant weight change since previous mammo? No Yes Lost _____lbs. Gained ____lbs.

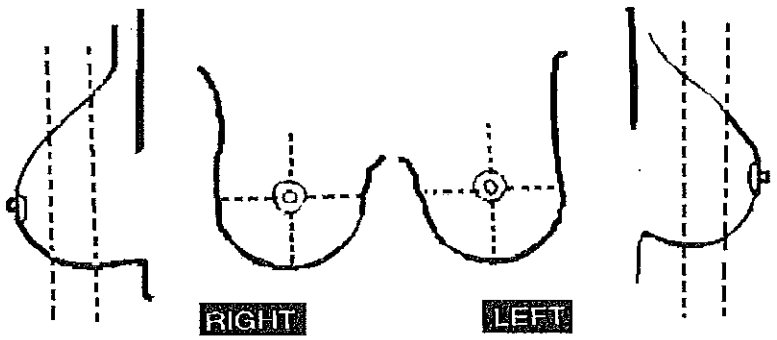
*

_____

Patient Signature

If you are here for a lump(s), or other areas in your breast which are of concern, tell the technologist.

Please do not write below this line.




Technologist: Please comment on the visual appearance of patient's nipples.

Normal ____Abnormal ____Explanation_____

X-ray Number _____Technologist_____