GREAT PLAINS REGIONAL MEDICAL CENTER

Mammography Department
1801 West 1st Street
Elk City, OK 73644
580-225-2511 EXT 426
Fax 580-821-5596

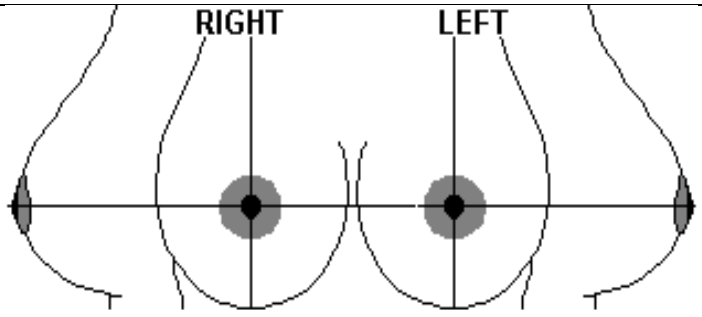
Name:_____ **Age:**_____ **Today's Date:**_____
DOB: _____**Phone Number:**_____**Physician:**_____
Was your last mammogram done here ☐ Yes ☐ No
If no, please give location and year _____
Have you passed menopause?: ☐ Yes ☐ No
*If no, please give date of last menstrual period*_____
If no, is there any possibility your are pregnant ☐Yes ☐No
Do you have breast implants? (saline or silicone) ☐ Yes ☐No
Are you taking Hormones? ☐Yes ☐No
How old were you when your first child was born (no children, leave blank) _____
When was the last time your physician examined your breast _____

REASON FOR TODAY'S EXAM (please check all that apply)
☐ Routine Screening ☐Breast Lump ☐Skin Changes
☐Nipple Discharge ☐Soreness ☐Pain
☐Follow-up Imaging (call back) ☐ Six month follow-up

PREVIOUS BREAST SURGERY (please check all that apply)
Breast Biopsy:

☐Needle Biopsy ☐Cyst Aspiration			When	Result
☐Lumpectomy (Surgical)	☐Right	☐ Left	_____	_____
Radiation Therapy	☐Right	☐ Left	_____	_____
Mastectomy	☐Right	☐Left	_____	_____
Breast Reduction	☐Right	☐Left	_____	_____
Breast Implant Removal	☐Right	☐Left	_____	_____

FAMILY HISTORY
Family history of breast cancer ☐Yes ☐No
If yes, please fill out ☐*Mother* ☐*Sister* ☐*Daughter* *Age:*_____
Have you tested positive for the BRCA 1 or 2 Gene? ☐Yes ☐No



Refers to: **O lump** **X Mastectomy** **● Mole** **XXXXXX Scar**