



Mammography Patient Questionnaire

(PLEASE ANSWER ALL QUESTIONS AND UPDATE ANY NEW INFORMATION)

DATE: _____

NAME:	MRN:	DOB:	AGE:
-------	------	------	------

ADDRESS:	ETHNICITY:
----------	------------

HOME PHONE:	WORK PHONE:	REFERRING PHYSICIAN:	EXAM DATE:
-------------	-------------	----------------------	------------

REASON FOR EXAM PLEASE DESCRIBE ANY PROBLEMS YOU ARE HAVING WITH YOUR BREASTS:

PREVIOUS MAMMOGRAMS IS THIS YOUR FIRST MAMMOGRAM? YES NO IF NO, WHEN AND WHERE HAVE YOU HAD A MAMMOGRAM?

MEDICAL HISTORY AGE AT HYSTERECTOMY AND/OR OVARY(S) REMOVED, IF ANY: _____ **ORAL CONTRACEPTIVE USE** _____

AGE AT MENOPAUSE: _____ DATE OF LAST PERIOD: ____/____/____ AGE AT FIRST PERIOD: _____ NO. OF DELIVERIES: _____

BREAST PROBLEMS	NO	YES	WHICH BREAST?	HOW LONG?
ANY NEW BREAST LUMPS?	_____	_____	_____	_____
BREAST PAIN OR TENDERNESS?	_____	_____	_____	_____
NIPPLE DISCHARGE (COLOR)?	_____	_____	_____	_____
NIPPLE RETRACTION (PULLING INWARD)?	_____	_____	_____	_____
CRUSTING OR REDNESS OF NIPPLE?	_____	_____	_____	_____
SKIN PUCKERING OR DIMPLING?	_____	_____	_____	_____
REDNESS OR SWELLING?	_____	_____	_____	_____
OTHER BREAST PROBLEMS?	_____	_____	_____	_____

PERSONAL HISTORY

HAVE YOU HAD BREAST CANCER? _____

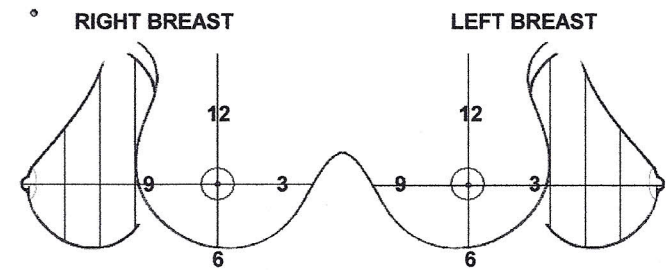
IF YES, PLEASE DESCRIBE: _____

HAVE YOU HAD NON-BREAST CANCER? _____

IF YES, PLEASE DESCRIBE: _____

PLEASE INDICATE THE DATE AND SIDE OF EACH OF THE FOLLOWING: MASTECTOMY, LUMPECTOMY, BIOPSY, RADIATION THERAPY, BREAST RECONSTRUCTION, BREAST IMPLANTS AND BREAST REDUCTION:

PROCEDURE	SIDE	DATE
_____	_____	_____
_____	_____	_____
_____	_____	_____



FAMILY HISTORY

HAS ANY BLOOD RELATIVE HAD BREAST CANCER? YES NO IF YES, PLEASE LIST EACH & THEIR RELATIONSHIP TO YOU: _____

HAS ANY BLOOD RELATIVE HAD NON-BREAST CANCER? YES NO IF YES, PLEASE LIST EACH & THEIR RELATIONSHIP TO YOU: _____

HORMONE USE TYPE / AGE AT FIRST USE / NO. OF MONTHS OF USE: _____

IMPLANTS

COMMENTS

SIGNATURE

I ATTEST THAT THE INFORMATION I HAVE PROVIDED ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO CONSENT FOR PATIENT	DATE	TECHNOLOGIST
--	------	--------------