Mammography Patient Questionnaire

DATE: ____________

(PLEASE ANSWER ALL QUESTIONS AND UPDATE ANY NEW INFORMATION)

NAME:	MRN:	DOB:	AGE:
ADDRESS:		ETHNICITY:	

HOME PHONE:	WORK PHONE:	REFERRING PHYSICIAN:	Email:

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?

ARE YOU PREGNANT? Yes ☐ No ☐

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

RIGHT BREAST LEFT BREAST

12 9 3 6   12 9 3 6

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