Providence Breast Health Center
Fish Pond at Cobbs Drive

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? _____

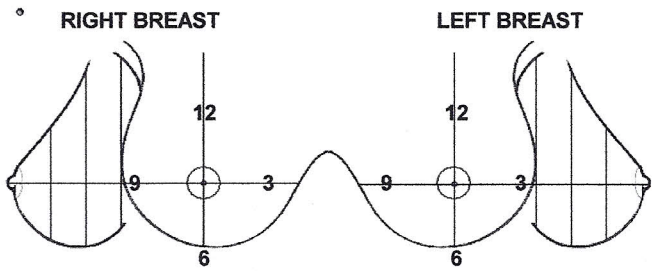
IF YES, PLEASE DESCRIBE: _____

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