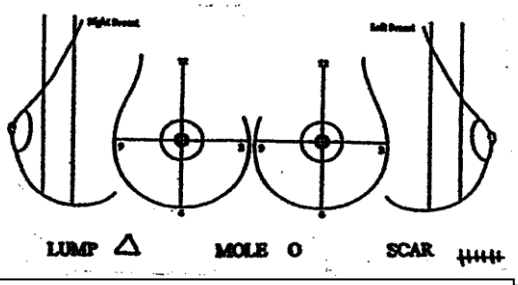
PATIENT MAMMOGRAM QUESTIONNAIRE

Name_____ Date_____
Age_____ Date of Birth_____ Referring Dr. _____
Are You Pregnant?_____ Last Menstrual Period _____
Date of Last Breast Exam By Your Doctor_____
Date of Last Mammogram _____ Where it was Done _____

Clinical Information

☐ First Mammogram ☐ Routine Screening ☐ Diagnostic (Problem)

YES	NO	
☐	☐	Personal History of Breast Cancer Age at Diagnosis _____
☐	☐	Personal History of Cancer Other Than Breast Cancer Type _____
☐	☐	History of Radiation Therapy Treatment
☐	☐	History of Chemotherapy Treatment
☐	☐	Family History of Breast Cancer Relationship to you _____ Age at Diagnosis _____
☐	☐	Do You Have Any Recent Onset of Breast Pain? RIGHT LEFT
☐	☐	Are You Feeling Any Current Masses or Lumps? RIGHT LEFT
☐	☐	Do You Have Any Nipple discharge? RIGHT LEFT Color_____
☐	☐	Do You Have Any Skin or Nipple Retraction? RIGHT LEFT
☐	☐	Do You Have Skin Thickening? RIGHT LEFT
☐	☐	Are Your Currently Taking Hormones?
☐	☐	Do You Have Breast Implants?
☐	☐	Have You Had a Breast Reduction?



Surgical History

Right Breast	Left Breast		Benign	Malignant	Date
☐	☐	Breast Biopsy	☐	☐	_____
☐	☐	Lumpectomy	☐	☐	_____
☐	☐	Mastectomy	☐	☐	_____
☐	☐	Cyst Aspiration	☐	☐	_____

What influenced you to choose our facility for your Radiology needs?
Doctor referral ☐ Advertising ☐ Friend or Family ☐ Other ☐ _____

The above information is correct to the best of my knowledge. _____
Signature & Date