Mammography Patient Questionnaire

Date: _____ **Your Referring Physician:** _____

Name: _____ **DOB:** _____

Have you had a previous mammogram? □ Yes □ No

When: _____ Where: _____

Are you having any of these problems now with your breasts:

New Lump: □ Yes □ No New Pain: □ Yes □ No Nipple Discharge: □ Yes □ No

Have you had any of these procedures on your breasts:

Needle Biopsy:	Right: □ Yes □ No	Left: □ Yes □ No	When: _____
Surgical Biopsy	Right: □ Yes □ No	Left: □ Yes □ No	When: _____
Lumpectomy	Right: □ Yes □ No	Left: □ Yes □ No	When: _____
Mastectomy	Right: □ Yes □ No	Left: □ Yes □ No	When: _____
Reduction	Right: □ Yes □ No	Left: □ Yes □ No	When: _____
Implants	Right: □ Yes □ No	Left: □ Yes □ No	When: _____
Radiation	Right: □ Yes □ No	Left: □ Yes □ No	When: _____

Have you ever had cancer? □ Yes □ No If Yes, please specify?_____

Is there breast cancer in your family? □ Yes □ No

In whom: Sister: □ Yes □ No Mother: □ Yes □ No Daughter: □ Yes □ No Other:

Age: _____ _____ _____ _____

Are you pregnant? □ Yes □ No Date of last period? _____ **How many full term pregnancies?** ___

Are you taking hormone replacement? □ Yes □ No When did you start? _____

Please check your menopausal status:

Premenopausal: □ Yes □ No Currently in menopause: □ Yes □ No Postmenopausal: □ Yes □ No

Have you had a weight change since your last Mammo? □ Loss □ Gain How much:_____ lbs

Tech Notes:

_____

Tech: _____

Equipment Cleaned: _____