



Mammography Patient Questionnaire

(PLEASE ANSWER ALL QUESTIONS AND UPDATE ANY NEW INFORMATION)

NAME:	SS#:	DOB:	AGE:	DATE: _____
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ADDRESS: _____

HOME PHONE:	WORK PHONE:	REFERRING PHYSICIAN:	EXAM DATE:
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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
NUMBER OF PREGNANCIES: _____ DATE OF LAST PERIOD: _____ NUMBER OF DELIVERIES: _____ AGE AT FIRST PERIOD: _____ AGE AT FIRST DELIVERY: _____ AGE AT MENOPAUSE: _____	_____ _____ NUMBER OF MONTHS OF USE: _____

PERSONAL HISTORY

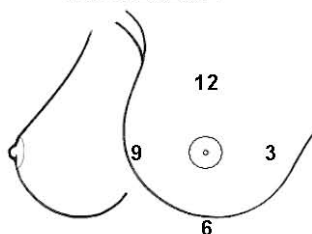
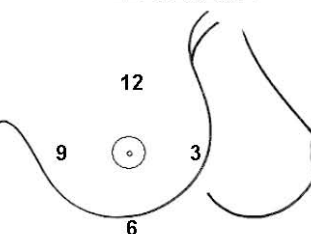
HAVE YOU HAD BREAST CANCER? _____

IF YES, PLEASE DESCRIBE: _____

HAVE YOU HAD ANY OTHER TYPE OF 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
_____	_____	_____		
_____	_____	_____		
_____	_____	_____		

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

I UNDERSTAND THAT MAMMOGRAPHY DOES NOT DETECT APPROXIMATELY 10% OF BREAST CANCERS AND THAT BREAST SELF-EXAMINATION AND PHYSICAL EXAMINATION BY A PHYSICIAN ARE ALSO NECESSARY TO DETECT BREAST CANCER! ATTEST THAT THE ANSWERS I HAVE PROVIDED TO QUESTIONS ARE CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE

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