



Mammography Questionnaire

Patient Name _____ DOB _____
Physician _____ When was your last Clinical Breast Exam? _____
Is this your first mammogram? YES / NO If no, When and Where was your last mammogram?
Date _____ Place _____

Are you having any problems with your breast? _____

If YES, Please check the following symptoms you currently have:

LUMP OR THICKENING RIGHT _____ LEFT _____ INFECTION OR INFLAMATION RIGHT _____ LEFT _____
PAIN OR TENDERNESS RIGHT _____ LEFT _____ RECENT BREAST INJURY RIGHT _____ LEFT _____
NIPPLE DISCHARGE RIGHT _____ LEFT _____ DISCHARGE COLOR _____
NIPPLE ABNORMALITY RIGHT _____ LEFT _____ FIBROCYSTIC CHANGE RIGHT _____ LEFT _____
LARGE LYMPH NODES RIGHT _____ LEFT _____ OTHER RIGHT _____ LEFT _____

Have you had breast cancer? _____ If YES, in which breast? _____

Have you had any other type of cancer? _____ If YES, please list the type _____

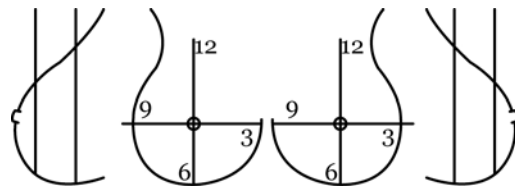
FAMILY HISTORY OF BREAST CANCER Please list any relatives that have had breast cancer.

Mother _____ Daughter _____ Sister _____ Son _____ Father _____ Brother _____
Grandmother _____ Aunt _____ Cousin _____
Other _____

PLEASE CHECK ANY OF THE FOLLOWING PROCEDURES YOU HAVE HAD

Implants RIGHT _____ LEFT _____
Breast MRI RIGHT _____ LEFT _____
Cyst Aspiration RIGHT _____ LEFT _____
Needle Biopsy RIGHT _____ LEFT _____
Surgical Biopsy RIGHT _____ LEFT _____
Breast Reduction RIGHT _____ LEFT _____
Lumpectomy (Cancer) RIGHT _____ LEFT _____
Mastectomy (Cancer) RIGHT _____ LEFT _____
Reconstruction RIGHT _____ LEFT _____

TYPE: SALINE / SILICON / DON'T KNOW



Have you had chemotherapy? _____
Have you had radiation therapy? _____
Have you had Tamoxifen or Evista? _____

PLEASE CHECK ANY OF THE FOLLOWING PROCEDURES YOU HAVE HAD

Are you pregnant? YES / NO Last Period _____
Are you taking birth control pills? YES / NO
Have you had a hysterectomy? YES / NO Age _____ Were your ovaries removed? YES / NO
Are you currently taking hormones? _____ Have you ever taken hormones? _____
How Many times have you been pregnant? _____ Number of live births? _____
Age when you delivered your 1st birth? _____ Age at last delivered birth? _____

Patient's Signature _____ Date _____