Mammography Questionnaire

Today's Date: _____

Name: _____ Contact phone number (s): _____

Age: _____ DOB: ____/____/_____ Ordering Physician: _____

Date/location of previous Mammogram/Breast Ultrasound: _____

_____

Reason for today's exam (circle): **ROUTINE** **FOLLOW-UP** **CALL-BACK** **NEW PROBLEM** **OTHER**

CURRENT PROBLEMS

Please circle "NO" or "RIGHT/LEFT"

Lump	NO	RIGHT	LEFT	Notes: _____
Pain	NO	RIGHT	LEFT	Notes: _____
Nipple Discharge	NO	RIGHT	LEFT	Notes: _____
Nipple Inversion	NO	RIGHT	LEFT	Notes: _____
Skin Dimpling	NO	RIGHT	LEFT	Notes: _____
Other	NO	RIGHT	LEFT	Notes: _____

PREVIOUS BREAST PROCEDURES

(List dates and other relevant information)

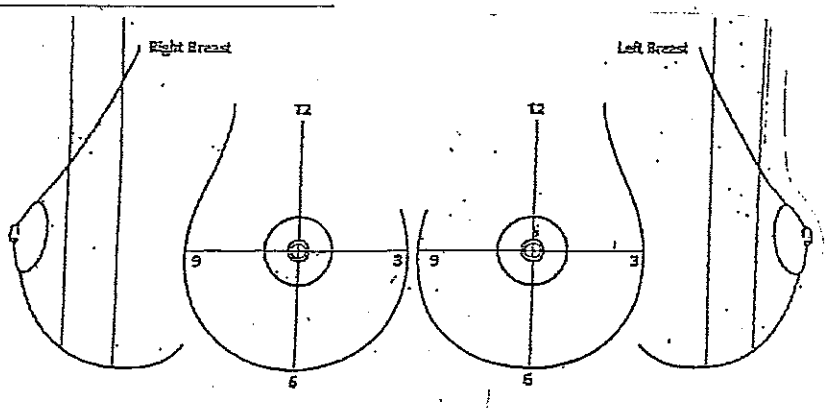
Aspirations	NO	RIGHT	LEFT	Notes: _____
Biopsy	NO	RIGHT	LEFT	Notes: _____
Lumpectomy	NO	RIGHT	LEFT	Notes: _____
Radiation	NO	RIGHT	LEFT	Notes: _____
Mastectomy	NO	RIGHT	LEFT	Notes: _____
Reduction	NO	RIGHT	LEFT	Notes: _____
Implants	NO	RIGHT	LEFT	Notes: _____

PERSONAL/FAMILY HISTORY

Are you pregnant? Any chance of being pregnant?	NO	YES	If yes, please inform technologist immediately!
Personal history of breast or ovarian cancer?	NO	YES	Notes: _____
Family history of breast or ovarian cancer?	NO	YES	Notes: _____
Do you examine your breasts regularly?	NO	YES	Notes: _____
Are you taking hormones or birth control pills?	NO	YES	Notes: _____
Do you still have periods (menses)?	NO	YES	If yes, when was your last period? _____

Any other relevant history, concerns, or questions? _____

Patient Signature : _____



Tech Notes : _____