Mammography Questionnaire

Name	Date	Date of Birth
Phone	**Email**	**MRN**

Referring MD

GYN MD

What is the reason you are having a breast imaging exam?

- ☐ Routine screening. I have no current breast problems.
- ☐ I am here for a follow-up from a prior visit (3 mo, 6 mo)
- ☐ I am here for a new breast problem.

Describe your symptoms

Lumps or masses?	☐ Yes ☐ No	☐ L ☐ R
Nipple discharge?	☐ Yes ☐ No	☐ L ☐ R
Inverted nipples?	☐ Yes ☐ No	☐ L ☐ R
Pain, swelling or tenderness?	☐ Yes ☐ No	☐ L ☐ R

Are you or could you be pregnant? ☐ Yes ☐ No

Is this your first mammogram? ☐ Yes ☐ No

If no, when and where did you have your last mammogram?

When? _____ Where? _____

Last menstrual period _____

Age at menopause _____ ☐ N/A

Number of pregnancies/children _____

Age at first full term pregnancy _____ ☐ N/A

Have you had breast trauma (i.e. bruises) in the last year? ☐ Yes ☐ No

Breast-fed in last 3 months? ☐ Yes ☐ No

Have you had a weight change of > 10 lbs since your last visit? ☐ Up ☐ Down

Do you have implants? ☐ Yes ☐ No

☐ Silicone ☐ Saline ☐ Prepectoral ☐ Retropectoral

Month/Year _____

Are you Ashkenazi Jewish? ☐ Yes ☐ No

I acknowledge the information I have provided is accurate to the best of my knowledge.

Signature

Date

Have you ever had hysterectomy? ☐ Yes ☐ No

Have you ever had ovaries removed? ☐ Yes ☐ No

Breast surgery or biopsy? ☐ L ☐ R ☐ Both

Are you on birth control? ☐ Yes ☐ No

Have you ever taken hormones? ☐ Yes ☐ No

☐ currently using ☐ in the past

Have you ever had chemo or radiation therapy?

When? _____

Have you ever had breast cancer? ☐ L ☐ R ☐ Both

When? _____

Have you had any other cancer? ☐ Yes ☐ No

When? _____ What kind? _____

Family history of breast, ovarian, or other cancer?

Relative _____ Age _____ Type _____

Relative _____ Age _____ Type _____

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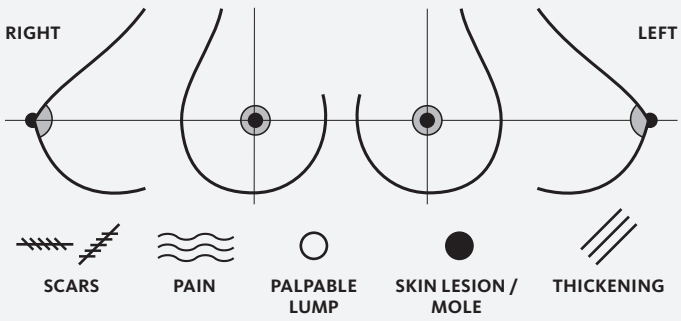

Tech comments

List additional views	Tech initials

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