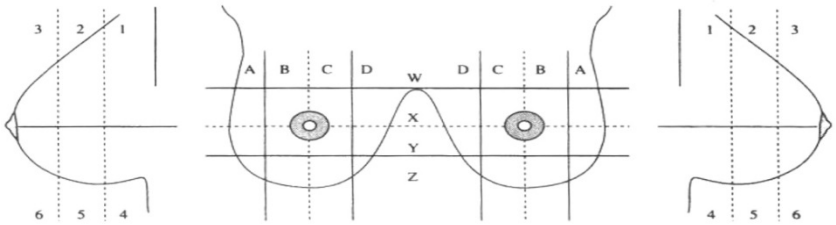
Mammography Questionnaire

Name: _____ Date: _____ Age: _____ Ethnicity: _____

1. Have you ever had a mammogram before?..... Yes: ___ No: ___
   a. If Yes, where and when (month, year) was the last one? _____
2. Do you still have a monthly menstrual cycle? ……..……..... Yes: ___ No: ___
   a. If Yes, when was your last period? _____
3. Are you pregnant or nursing a baby? ……. Yes: ___ No: ___
4. Do you have breast implants? ……. Yes: ___ No: ___
5. Have you had any breast biopsies, surgeries, or reductions? ……. Yes: ___ No: ___
6. Have you ever had breast cancer? …….. Yes: ___ No: ___
   a. If Yes, which side? Left: ____ Right:_____
7. Were either of your breasts removed? ..... Yes:___ No:___
   a. If Yes, which side? Left: ___ Right:___
8. Have you ever had radiation treatment to your breasts? ……. Yes: __ No: ___
   a. If Yes, which side? Left: ____ Right:___
9. Did your mother or sister have a history of breast cancer? ……... Yes: ___ No: ___
   a. If Yes, who and what age: _____
10. Have you recently found a lump in one of your breasts? …….. Yes: ___ No: ___
    b. If Yes, on which breast? Left: __ Right: __
11. Do you have any problems with your breasts? ……. Yes: ___ No: ___
    a. If Yes, please describe: _____
13. Are you currently taking any medication or hormones? …….. Yes: ___ No: ___
    a. If Yes, please list: _____
14. Are you currently smoking? Yes: __ No: ___ Are you a former smoker? Yes: __ No: ____
15. **When was the last time a doctor examined your breasts (month; year)? _____**



Please list any medical problems, medical history, and allergies: _____

_____

_____

Patient Signature: _____Tech Signature: _____