

SCREENING MAMMOGRAPHY QUESTIONNAIRE

PLEASE BRING THIS COMPLETED FORM WITH YOU ON YOUR APPOINTMENT DAY FOR MAMMOGRAM



Name: _____ SSN: _____

Address: _____

DOB: _____ Age: _____ Home phone: _____ Work phone: _____

Referring physician: _____ Exam Date: _____

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: _____

No. of pregnancies _____ Date of last period _____

No. of deliveries _____ Age at first period _____

Age at first delivery _____ Age at menopause _____

Oral contraceptive use

Self breast exam? Y or N

Personal history

Have you had breast cancer _____

If yes, please describe: _____

Have you had non-breast cancer? _____

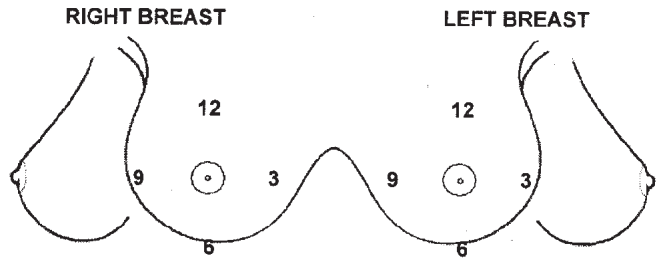
If yes, please describe: _____

Have you had chemotherapy or radiation therapy? _____

If yes, please describe: _____

Please indicate the date and side of each of the following: mastectomy, lumpectomy, cyst aspiration, biopsy, radiation therapy, breast reconstruction, breast implants and breast reduction:

Table with 3 columns: Procedure, Side, Date



Family history

Has any blood relative had breast cancer? Yes No If yes, please list each and their relationship to you:

Has any blood relative had ovarian cancer? Yes No If yes, please list each and their relationship to you:

Hormone use Type/age at first use/No. of months of use:

Implants

Signature I attest that the information I have provided on this form is true to the best of my knowledge. Date