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? ____________________________________

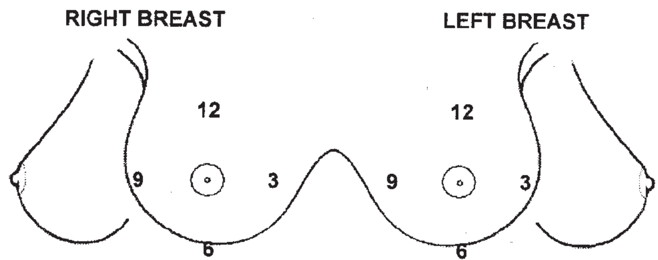
If yes, please describe: ____________________________________

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:

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:

Hormore 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**