Name: ______________________
Age: ______ Date of Birth: __________
Date: ______________________

Patient Questionnaire

5801699 – Breast Center Form - Mammogram Questionnaire

Exam Data

Have you had a significant weight ☐ gain / ☐ loss? How much: ____________________
Is this your first mammogram ever? ☐ Yes ☐ No If no, date of last: ________________
Location of previous mammogram/breast ultrasound: ____________________________

Reason for today's exam (select one)

☐ Routine screening
☐ Additional evaluation requested from prior study
☐ Follow-up at short interval from prior study
☐ Additional evaluation requested at current screening
☐ Diagnostic Exam

Indicate all problems that you currently have:

☐ New lump or thickening ☐ New nipple abnormality
☐ New bloody discharge ☐ Pain
If yes to pain, is it severe or has it been there for more than 4 weeks? ______________________________
☐ New non-bloody discharge
☐ Skin thickening or retraction on clinical examination
☐ Right ☐ Left

Breast Exam

Have you had a recent breast exam (not mammogram) by a healthcare personnel?
☐ Yes ☐ No Date: ___________
Are you pregnant now? ☐ Yes ☐ No

Risk Factors (Indicate any that apply to you)

Age of first period: ______
☐ Hysterectomy
☐ Ovaries removed
☐ Have you been through menopause (post-menopausal)? ☐ Yes ☐ No
☐ How many pregnancies: _________
☐ Age of first birth: _______
☐ Date of last period (if in last year): ____________
Hormone Replacement: ☐ Estrogen Only ☐ Combined Estrogen/Progesterone
How long? ______________________________
Current? _______________________________

Procedures	Date	Left	Right
Breast Implants	_____	___	___
Breast reduction	_____	___	___
Cyst aspiration	_____	___	___
Needle biopsy if yes, see below	_____	___	___
Excisional biopsy if yes, see below	_____	___	___
Lumpectomy for cancer	_____	___	___
Mastectomy	_____	___	___
Radiation Therapy	_____	___	___

Specify how many of each procedure on appropriate line for side.

Have you ever received chemotherapy for any type of cancer? ☐ Yes ☐ No

Breast Biopsy results: ☐ Hyperplasia ☐ Atypical Hyperplasia ☐ LCIS ☐ Benign
Did you have: ☐ Radiation ☐ Chemotherapy ☐ Tamoxifen/Raloxifene (Evista) / Letrozole (Femara)

Patient Signature: ______________________________ Date: ________ Time: _______

4.17, rev 11.16

Name: ______________________
Age: ______ Date of Birth: __________
Date: ______________________

Patient Questionnaire

5801699 – Breast Center Form - Mammogram Questionnaire

I decline these questions: _________ (Initial)

High Risk Breast Cancer Questionnaire

Personal History of Breast Cancer? ☐ Yes ☐ No
Personal History of Ovarian Cancer? ☐ Yes ☐ No

Do you have relatives who have had **Ovarian Cancer**?
- Relationship: __________________ ☐ Maternal ☐ Paternal Age at Diagnosis: __________
- Relationship: __________________ ☐ Maternal ☐ Paternal Age at Diagnosis: __________

Do you have relatives who have had **Pancreatic Cancer**?
- Relationship: __________________ ☐ Maternal ☐ Paternal Age at Diagnosis: __________
- Relationship: __________________ ☐ Maternal ☐ Paternal Age at Diagnosis: __________

Do you have relatives who have had **Prostate Cancer**?
- Relationship: __________________ ☐ Maternal ☐ Paternal Age at Diagnosis: __________
- Relationship: __________________ ☐ Maternal ☐ Paternal Age at Diagnosis: __________

Do you have relatives who have had **Colon Cancer**?
- Relationship: __________________ ☐ Maternal ☐ Paternal Age at Diagnosis: __________
- Relationship: __________________ ☐ Maternal ☐ Paternal Age at Diagnosis: __________

Do you have relatives who have had **Breast Cancer**?
- ☐ Mother Age at Diagnosis: _____
- ☐ Daughter Age at Diagnosis: _____
- ☐ Sister Age at Diagnosis: _____
- ☐ Maternal Grandmother Age at Diagnosis: _____
- ☐ Maternal Aunt Age at Diagnosis: _____
- ☐ Niece Age at Diagnosis: _____
- ☐ First Cousin Age at Diagnosis: _____
- ☐ Paternal Grandmother Age at Diagnosis: _____
- ☐ Paternal Aunt Age at Diagnosis: _____
- ☐ Male Age at Diagnosis: _____

______________________________ __________ __________
Patient Signature Date Time

______________________________ __________ __________
Tech Signature Date Time