Mammography Patient History Questionnaire

HAVE YOU EVER HAD A BREAST PROCEDURE OR SURGERY?

O No O Yes

	LEFT	RIGHT	AGE	DATE	DIAGNOSIS:
BIOPSY	O	O	_____	_____	_____
MASTECTOMY	O	O	_____	_____	_____
CYST ASPIRATION	O	O	_____	_____	_____
IMPLANTS	O	O	_____	_____	_____
REDUCTION	O	O	_____	_____	_____
LUMPECTOMY	O	O	_____	_____	_____

FAMILY HISTORY OF BREAST CANCER

O No O Yes

AGE	AGE	AGE	AGE
Mother_____	Daughter(s)_____	Father's Mother_____	Mother's Father_____
Aunt_____	Mother's Mothers____	Father's Aunt_____	Father's Father_____
Sister_____	Mother's Aunt_____	Father_____	

MENSTRUAL HISTORY: Age at first period_____ Age at last period_____
Are you still menstruating? Y N
Have you had a hysterectomy? Y N If YES-Age_____

Is there any possibility of pregnancy? No Yes Are you nursing? No Yes
Have you ever or are you now taking any of the following? Birth Control Pills_____
Hormone medication_____

Have you gained or lost weight in the past year? _____ How much? _____lbs
Date of last Clinical breast exam(physical exam by whom)_____

REASON FOR TODAY'S EXAM: *SCREENING:* ☐1st Mammogram ☐Annual
Physician recommended *DIAGNOSTIC* follow-up: ☐Pain ☐Mass or Lump ☐Discharge
☐Bleeding ☐Calcifications ☐Dimpling

LAST MAMMOGRAM PERFORMED

☐Here ☐Another location:_____
City & State:_____ Year:_____

I agree that all information on this form is correct to the best of my knowledge.

Patient Signature_____ Best Contact Number:_____

Date:_____

«PatientNumber»