Screening Mammography Questionnaire

Name:____ D.O.B.____/____/____ Sex: M / F MRN: __________

SCREENING MAMMOGRAM:

I have no breast related symptoms or complaints

I have a specific concern ____

Please note, if you have a specific concern such as a lump or focal and non-cyclical pain, you may need to obtain a referral for a diagnostic mammogram and reschedule your exam.

GENERAL HISTORY:

YES NO Is there any chance you may be pregnant? Date of last menstrual period?__________

YES NO Have you breast fed within the last 6 months?

YES NO Are you taking any type of hormones? If yes, how long?________________________

YES NO Do you have breast implants? If yes, type: Silicone Saline

YES NO Any prior imaging? Where/when? ____

YES NO Prior surgery or biopsy:

Side: right / left / both sides

Result: benign malignant atypia_____

*When:*____

YES NO Do you have a personal history of breast cancer?

Side: right / left / both sides

Type: ____

Age: _____________

YES NO Radiation treatments to your breast? R / L *When?* ____________________

YES NO Chemotherapy? *When?* ____

YES NO Hormonal therapy? *When?* ____

YES NO Do you smoke currently or have you ever smoked?

If YES, for how many years? ___________years

How many packs per day? _____ packs per day

How long ago did you quit? If still smoking, mark as “0”: _____ years ago

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I acknowledge that all the information given is accurate and thereby consent to have a Mammography examination performed on me.

Signature:____ Date:____/____/____

Technologist Notes: ____

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Technologist Initials: _________