

**MAMMOGRAPHY QUESTIONNAIRE**

Date: \_\_\_\_\_

**PERSONAL INFORMATION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Race: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Physician: \_\_\_\_\_

**MEDICAL MAMMOGRAPHY HISTORY**

- |     |     |   |
|-----|-----|---|
| Yes | No  |   |
| ___ | ___ | Have you had a previous mammogram? Where/ When? _____   |
| ___ | ___ | Have any of your BLOOD RELATIVES ever had breast cancer?<br>If yes, ___ Mother ___ Grandmother ___ Aunt ___ Sister ___ Daughter |
| ___ | ___ | Have you ever had breast cancer? Which breast? RT LT  |
| ___ | ___ | Have you ever taken hormones or birth control pills? If so, how long? _____   |
| ___ | ___ | Are you currently taking any hormones? If so, name? _____   |
| ___ | ___ | Do you currently have discharge from your breast? If so, which breast? RT LT  |
| ___ | ___ | Have you or your physician found a breast lump? If yes, when _____<br>which breast? RT LT                                       |
| ___ | ___ | Do you have any breast tenderness? If so, which breast? RT LT   |
| ___ | ___ | Have you had any breast biopsies, surgeries, reduction, or implants? If so, please explain.<br>_____                            |
| ___ | ___ | Are you or is there chance you could be pregnant? Last menstrual period _____   |
| ___ | ___ | Do you have any skin moles around or near your breast? Which breast? RT LT  |

Patient Signature: \_\_\_\_\_

**FOR MAMMOGRAPHY TECHNOLOGIST ONLY  
PLEASE DO NOT WRITE BELOW THIS LINE**

**RIGHT**

**LEFT**

Technologist Initials: \_\_\_\_\_

Radiologist Initials: \_\_\_\_\_