Please fax results to
Dr. _____
at _____

MAMMOGRAPHY QUESTIONAIRE

Today's Date: _____

Name:_____
Last Middle First

MRN(Medical Record Number) #: _____ Date of Birth: _ _ / _ _ / _ _
DD/ MM/ YY

P. O Box _____ District _____ Postal Code _____

Telephone #'s (w) _____ (h) _____ (c) _____

Doctor's name and contact details_____
(To whom the report should be sent)

1. Are you having any problems with your breasts: .....Yes☐ No☐

   If Yes, please check the boxes below for each breast.

Left		**Right**
☐	Lump	☐
☐	Discharge	☐
☐	Other	☐

   Describe _____

2. Have you had any previous Mammograms? .....Yes☐ No☐

   If Yes, date of last mammogram, _ _/ _ _/ _ _ Location_____
   DD/ MM/ YY

3. When was your last menstrual period? _ _/ _ _/ _ _
   DD/ MM/ YY

4. Do you have breast tenderness or pain at any time during the month? ..... Yes☐ No☐

   If Yes, which breast? ☐ Left ☐ Right ☐ Both Explain_____

5. Are you on hormone medication? .....Yes☐ No☐

   (Birth control pills or hormone replacement therapy)

   Type_____ Date started _ _/ _ _/ _ _
   DD/ MM/ YY

6. Are you pregnant? .....Yes☐ No☐

7. Have you had a hysterectomy(surgical removal of womb/uterus)?.....Yes☐ No☐

   If Yes, date _ _/ _ _/ _ _
   DD/ MM/ YY

8. Were your ovaries removed at any time? .....Yes☐ No☐

   If Yes, date _ _/ _ _/ _ _
   DD/ MM/ YY

9. Have any of the following relatives of yours had breast cancer?

   Mother ☐ Daughter ☐ Sister ☐ Father ☐ Brother ☐

   If Yes, age of Diagnosis_____ _____

10. Have you ever had a breast biopsy or surgery before? ……..Yes☐ No☐

    Left☐ **Right**☐ **Both**☐ Date: _ _/ _ _/ _ _ (DD/ MM/ YY)

    If Yes, type:

    a. Implants Yes☐ No☐ Date: _ _/ _ _/ _ _ (DD/ MM/ YY)

    b. Biopsy Yes☐ No☐ Date: _ _/ _ _/ _ _ (DD/ MM/ YY)

    c. Needle Aspiration Yes☐ No☐ Date: _ _/ _ _/ _ _ (DD/ MM/ YY)

    d. Mastectomy Yes☐ No☐ Date: _ _/ _ _/ _ _ (DD/ MM/ YY)

    e. Other _____ Date: _ _/ _ _/ _ _ (DD/ MM/ YY)

11. Have you ever had Breast Cancer? ……..Yes☐ No☐

    If Yes, details_____ _____

12. Name of insurance Provider (if any)_____

Office Use Only

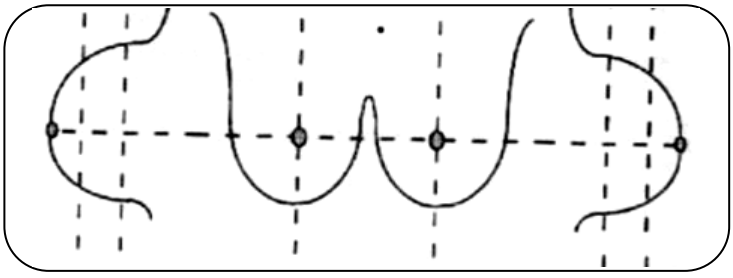
Date mammogram done _____

Indicate scars etc. on diagram

Report sent to: Attending Physician ☐

No Attending Physician ☐

Date sent: ___ /___ /___



_____

Mammographer