Washington Township Medical Foundation
Part of Washington Hospital Healthcare System

1900 Mowry Ave., Ste. 309
Fremont, CA 94538
Ph: (510) 248-1450
Fax: (510) 742-8244

MAMMOGRAPHY QUESTIONARE

Patient Name:____ Date:____________________

1. When was your last mammogram? ________________________
   Where was your last mammogram? ______________________________
2. Are you currently having any breast problems or symptoms? ❑ R ❑ L ❑ Yes ❑ No
   If NO, go to question #3.
   If YES, please indicate which problems and which breast:
   - Breast Lump? ❑ R ❑ L ❑ Yes ❑ No
   - Pain or Tenderness? ❑ R ❑ L ❑ Yes ❑ No
   - Nipple Discharge? ❑ R ❑ L ❑ Yes ❑ No
   - Other? _________________________ ❑ R ❑ L ❑ Yes ❑ No
3. Have you ever had breast cancer? ❑ R ❑ L ❑ Yes ❑ No
4. Have you ever had a breast biopsy or needle aspiration for benign breast disease? ❑ R ❑ L ❑ Yes ❑ No
   If yes, please check: ❑ Fibrocystic ❑ Infection ❑ Fibroadenoma ❑ Other
5. Has your mother, sister, or daughter ever had breast cancer? ❑ Yes ❑ No
   If yes, please circle which relative.
   Has a distant relative (i.e. aunt, grandmother) ever had breast cancer? ❑ Yes ❑ No
6. Were you over 30 years old when you had your first child? ❑ Yes ❑ No
7. Are you currently, or have you ever taken:
   - Hormone Replacement Therapy (HRT)? ❑ Yes ❑ No
   - Birth Control Pills? ❑ Yes ❑ No
8. Other things we need to know:
   - Radiation Therapy? ❑ Yes ❑ No
   - Breast Reduction? ❑ Yes ❑ No
   - Breast Augmentation? ❑ Yes ❑ No
   - Other: ____
   ____
9. Please mark any scars, moles, or palpable masses on the diagram.