

## MAMMOGRAPHY QUESTIONNAIRE

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

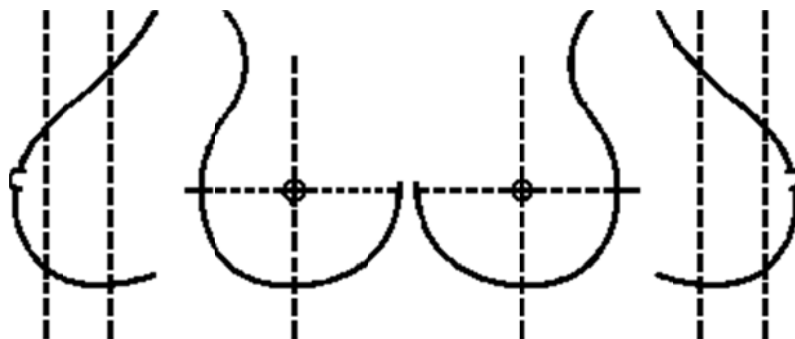
1. When was your last mammogram? \_\_\_\_\_  
Where was your last mammogram? \_\_\_\_\_
2. Are you currently having any breast problems or symptoms?  R  L  Yes  No  
If NO, go to question #3.  
If YES, please indicate which problems and which breast:
 

Breast Lump?	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pain or Tenderness?	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nipple Discharge?	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other? _____	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Yes	<input type="checkbox"/> 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)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Birth Control Pills?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Other things we need to know:
 

Radiation Therapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Breast Reduction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Breast Augmentation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other: _____		
9. Please mark any scars, moles, or palpable masses on the diagram.

Right



Left