

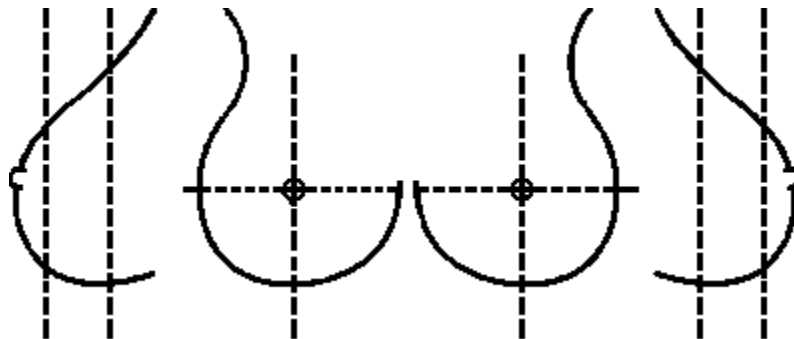
MAMMOGRAPHY QUESTIONNAIRE

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? 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.

Right



Left