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Westerly, RI
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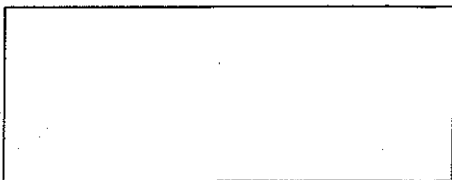

Mammogram Questionnaire

Patient's Name: ______________________ Date: __________

Referring MD: ______________________ Date of Birth: __________ Age: _____

1. Have you had a mammogram before? NO / YES Where and When: __________

____

2. Is this mammogram routine? NO / YES If NO, Why: __________

____

(Lump, discharge, retraction, thickening, pain, follow up for calcifications, follow up for densities)

3. Is there history of breast cancer in your family? NO / YES If YES, What age was it found:

   Myself: ________ Mother: ________ Sister: ________ Daughter: ________

   Other: ____

4. Have you had a child? NO / YES Your age when your 1st child was born: __________

5. Do you, or have you used hormones: (Estrogen, Premarin, Provera, Tamoxifen) NO / YES

   Which type: ______________ How long: ________ Still Using: ______

6. If you need additional views or ultrasound, how can we contact you during the day: By Mail ______

   Cell phone: ______________ Home phone: ______________

   Work Phone: ______________ Email: ______________

   If you have an answering machine can we leave a message? NO / YES

7. Do you need information on self breast exam? NO / YES

TO BE FILLED OUT BY THE TECHNOLOGIST

Are you pregnant? ______________ Last clinical breast exam: ______________

Check: Breast surface: ______ Nipples: Inverted: ______ Discharge: ______ How long: ______

Breast size discrepancy: ______ Which: ______ History of prior breast surgery: ______________

Comment: ____

____

____

____

Tech: ______________________ Date: ______________ Time: __________

(Signature)

TWH0011