Mammogram Questionnaire

Patient Name: ________________________________________________________ Date: ______________________
DOB: __________________________ Age: ______________ Referring: ______________________

Prior Mammograms
Facility: __________________________ Date: ______________________

Prior Breast Ultrasound
Facility: __________________________ Date: ______________________

Prior Breast MRI
Facility: __________________________ Date: ______________________

History:

Hormone Replacement: (please circle one)
Never Current More than 5 years ago Less than 5 years ago – when discontinued:

Currently pregnant: Y N Age at 1st birth: ______________________
Birth control: Y N Nursed in the last 6 months: Y N
Age at 1st Period: ____________ Last Normal Period: _________________

Menopausal status: (please circle one) Premenopausal Perimenopausal Postmenopausal – age:

Family History:

Breast Cancer (relationship & age of diagnosis)

_________________________________________________
_________________________________________________

Ovarian Cancer (relationship & age of diagnosis)

_________________________________________________
_________________________________________________

Genetic Testing: Y N Self Family Members: __________________________
Results: (please circle all applicable) Negative BRCA 1 BRCA 2

Personal Breast Cancer History:

Have you ever been diagnosed with breast cancer: Y N Right breast Left breast
Type of breast cancer: __________________________ Date of diagnosis: ______________________
Has Your Breast Cancer treatment ended: Y N Date of last treatment: ______________________
Mastectomy: R L Date: _______________ Lumpectomy (cancer): R L Date: _______________
Chemotherapy: R L Date: _______________ Radiation Therapy: R L Date: _______________

Personal Breast History: (please circle all that apply)

Implants: R L Date: _______________ Breast Reduction: R L Date: _______________
Cyst Aspiration: R L Date: _______________ Needle Biopsy: R L Date: _______________
Surgical Biopsy: R L Date: _______________

Current Breast Concerns: (please circle all symptoms that apply)

Breast lump R L How long? _______________ Nipple changes R L How long? _______________
Breast pain R L How long? _______________ Nipple discharge R L How long? _______________
Milky Clear Green Yellow Red/Brown

For Staff Use Only:

Mammography Comments:

Mammo Tech ____________ Radiologist ______________
Account # ____________ ABN Y N

(719) 785-9000
877-6-PENRAD • (877) 673-6723
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