PENRAD IMAGING

Life. Well seen.

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

Birth control: Y N

Age at 1st Period: _____

Age at 1st birth: _____

Nursed in the last 6 months: Y N

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? _____

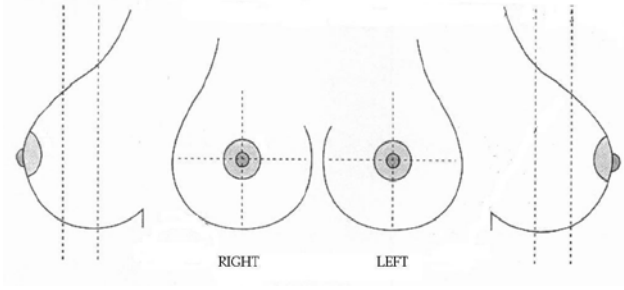
Nipple changes R L How long? _____

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

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