

MAMMOGRAPHY QUESTIONNAIRE



Today's Date:

Patient Name:

DOB:

AGE:

Previous Mammography:

YES ☐

NO ☐

Location:

Dates:

Your Age at 1st Period _____ Your Age at 1st Full-Term Pregnancy: _____

Are You Taking Hormones?

YES ☐

NO ☐

Menopause Status

☐ Not Yet

☐ Currently going through

☐ Completed

Age Completed: _____

Ashkenazi Jewish Ancestry

YES ☐

NO ☐

Significant Weight Loss

YES ☐

NO ☐

Significant Weight Gain

YES ☐

NO ☐

Breast Implants

LEFT ☐

RIGHT ☐

Breast Reduction

YES ☐

NO ☐

Prior Mastectomy

LEFT ☐

RIGHT ☐

New Breast Concern:

YES ☐

NO ☐

For How Long?

Lump

LEFT ☐

RIGHT ☐

Pain (Focal - One Spot)

LEFT ☐

RIGHT ☐

Nipple Discharge

LEFT ☐

RIGHT ☐

White/Bloody/Clear

Out of ONE or MULTI Nipple openings?

Other:

LEFT ☐

RIGHT ☐

Description:

Previous Biopsy

LEFT

Previous Biopsy

RIGHT

Benign ☐

Benign ☐

Malignant ☐

Malignant ☐

Mastectomy ☐

Mastectomy ☐

Lumpectomy ☐

Lumpectomy ☐

Radiation ☐

Radiation ☐

Chemotherapy ☐

Chemotherapy ☐

Excisional Biopsy ☐

Excisional Biopsy ☐

Family History Of Breast Cancer and/ or Ovarian Cancer (check all that apply)

Relative	AGE(S)	1 BREAST	BOTH BREASTS	OVARIAN
Maternal Grandmother	_____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Paternal Grandmother	_____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mother	_____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Maternal Aunt	_____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Paternal Aunt	_____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sister	_____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Daughter	_____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Genetic Testing - Self?

YES ☐

NO ☐

Self-Test Result:

Negative ☐

BRCA1 ☐

BRCA2 ☐

Tested Family Member?

YES ☐

NO ☐

WHO:

Results:

Negative ☐

BRCA1 ☐

BRCA2 ☐

PID:

STAFF USE ONLY:

TECH:

