

Office Use Only MRN _____

Date: __/__/__

MAMMOGRAM QUESTIONNAIRE

Name: _____ Age: _____ Referring Doctor: _____

Previous mamogram? No Yes, Year _____ Facility: _____

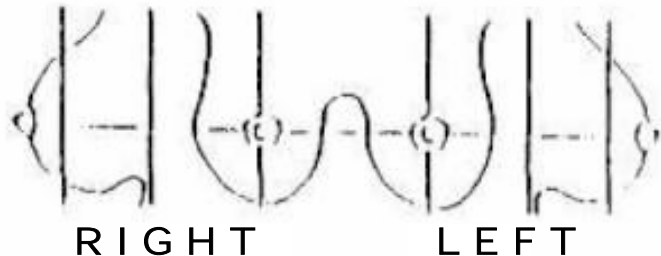
Reason for Exam: <input type="checkbox"/> BaseLine <input type="checkbox"/> Screening <input type="checkbox"/> Follow up (<input type="checkbox"/> LT <input type="checkbox"/> RT Note: _____)
Are you having problems with your breasts: <input type="checkbox"/> No <input type="checkbox"/> Yes, If yes, for how many months? _____
If yes, check all that apply: Lump <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both
Pain <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both
Discharge <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both Type of discharge: _____
Other <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both Other, specify: _____

Have any blood relatives (not married) had breast cancer? <input type="checkbox"/> No <input type="checkbox"/> Yes Don't Know
Relation: _____ Diagnosed at what age? _____
Have you had breast cancer? <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Right breast <input type="checkbox"/> Left breast Both breasts

Have you had a breast biopsy or surgery before? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, check all that apply)
Needle Biopsy <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both LT Date: __/__/__ RT Date: __/__/__
Mastectomy <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both LT Date: __/__/__ RT Date: __/__/__
Lumpectomy <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both LT Date: __/__/__ RT Date: __/__/__
Implants <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both LT Date: __/__/__ RT Date: __/__/__
Reduction <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both LT Date: __/__/__ RT Date: __/__/__
Other _____ <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both LT Date: __/__/__ RT Date: __/__/__

Attention: The radiologist may request that you come back for additional evaluation. Depending on the type of breast tissue, the finding and the area of concern will depend on the type of addition testing needed. Please provide us with the best way to contact you if you need additional testing.
Home Ph: (___) ___-___ <input type="checkbox"/> Day <input type="checkbox"/> Evening Work: (___) ___-___ <input type="checkbox"/> Day <input type="checkbox"/> Evening
Is it acceptable to leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> NO Cell: (___) ___-___ <input type="checkbox"/> Day <input type="checkbox"/> Evening

TECHNOLOGIST Comments



RADIOLOGIST Comments
