DOCTORS IMAGING GROUP

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Patient Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ MRN: _____

MAMMOGRAPHY QUESTIONNAIRE

Are you Possibly Pregnant? NO YES Are you currently taking hormones? NO YES

Have you had a mammogram before? NO YES If yes, what facility? _____When?_____

Age of First Menstrual Period: _____ Menopause Age:_____

CURRENT BREAST CONCERNS

NEW lumps	NO YES	RIGHT	LEFT	How long? _____	
NEW pain	NO YES	RIGHT	LEFT	How long? _____	
NEW nipple discharge	NO YES	RIGHT	LEFT	How long?_____Color?_____	
NEW skin thickening	NO YES	RIGHT	LEFT	Describe: _____	

SURGICAL PROCEDURES/HISTORY

History of Breast Cancer	NO YES	RIGHT	LEFT	Date:_____Type:_____	
Mastectomy	NO YES	RIGHT	LEFT	Date:_____	
Lumpectomy/ Partial Mastectomy	NO YES	RIGHT	LEFT	Date:_____	
Radiation	NO YES	RIGHT	LEFT	Date:_____	
Chemotherapy	NO YES	RIGHT	LEFT	Date:_____	
Biopsy or Surgery	NO YES	RIGHT	LEFT	Date:_____Resuts: Cancer/No Cancer	
Breast Implants	NO YES	RIGHT	LEFT	Date:_____Type:_____	
Breast Reduction/Lift	NO YES	RIGHT	LEFT	Date: _____	
History of any other type of Cancer	NO YES	If yes, what type?: _____			

Have any of the following family members been diagnosed with breast cancer?

Mother	NO	YES	If yes, age diagnosed: _____
Sister	NO	YES	If yes, age diagnosed: _____
Daughter	NO	YES	If yes, age diagnosed: _____

Patient Signature: _____Date:_____

TECHNOLOGIST USE ONLY

Type of exam being performed today: **ROUTINE BASELINE DIAGNOSTIC R/L/B QUICKSCREEN**

Mass or Lump	R	L	NEW	CHRONIC	
Pain	R	L	NEW	CHRONIC	Site: _____
Nipple Inversion	R	L	NEW	CHRONIC	
Nipple Discharge	R	L	GUIAC: POS/NEG		Color: _____
Prior Exam Here?	N	Y	Most Recent Date: _____		
Outside Prior Films Requested?			N	Y	

Radiologist: _____

Technologist: _____

Room: _____

Comments: _____