MAMMOGRAPHY QUESTIONNAIRE

Location: Brick □ Cape May Court House □ EHT □ Festival □ Galloway □ Somers Point □ Wall□
Name _____ Date _____

DOB _____ / _____ / _____ Age _____ Home Telephone _____

Referring Physician _____

❒ Routine Screening ❒ Follow-up of prior mammogram finding ❒ Other
_____

Previous Mammogram ❒No ❒Yes
When _____
Facility _____
Address _____

Previous Breast Ultrasound ❒No ❒Yes
When _____
Facility _____

Last Breast Exam by Physician or Nurse Pracitioner?_____ _____
(Name) (Date)

Are you pregnant? ❒No ❒Yes
Are you breast feeding? ❒No ❒Yes

Current Breast Problem ❒ None
Circle location: Right, Left or both where applicable.
State when in space provided:

			When?
Lump	Right	Left	_____
Pain	Right	Left	_____
Nipple Discharge	Right	Left	_____
Color Discharge ❒ Bloody ❒ Clear ❒ Other:_____			
Recent Nipple Inversion	Right	Left	_____
Skin Dimpling	Right	Left	_____

Treatment for Breast Problem ❒ None

			When?
Surgical Biopsy for Benign Disease	Right	Left	_____
Surgeon's name_____			
Location_____			
Aspiration	Right	Left	_____
Stero Biopsy	Right	Left	_____
Ultrasound Guided Biopsy			

	Right	Left
_____		

Do you have breast implants? ❒ No ❒ Yes
❒ Saline ❒ Silicone When?
_____

Have you had breast reduction? ❒ No ❒ Yes
When?
_____

Prior High Risk Breast Problems ❒ None
❒ Atypical hyperplasia Date:_____
❒ LCIS (Lobular Carcinoma In Situ) Date:_____
❒ Papillomatosis Date:_____
❒ Other Date:_____
❒ Hormonal Therapy Date:_____
❒ Herceptin Date:_____

Prior Cancer
❒ None
❒ Uterine ❒ Cervical ❒ Ovarian
❒ Colon ❒ Other_____

Family History of Breast Cancer ❒None

	Age Diagnosed
Mother	_____
Sister	_____
Maternal / Paternal Aunt	_____
Maternal / Paternal Grandmother	_____
Daughter	_____
First Cousin	_____
Male Breast Cancer	_____
Other _____	_____

Genetic Testing BRACA 1 or 2 ❒ No ❒ Yes

If YES - ❒ Neg ❒ Pos

Ethnicity
❒ White (non-hispanic)
❒ African American
❒ Ashkenazi Jew
❒ Hispanic
❒ Other _____

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MAMMOGRAPHY QUESTIONNAIRE

When?

Breast Cancer Right Left _____
Type, if known _____
Lumpectomy Right Left _____
Mastectomy Right Left _____
Surgeon's name _____
Radiation Tx _____

Gestational History

Age at first period _____
Age at last period _____
Age at time of first pregnancy _____
Number of pregnancies _____

Medications ❒ None

How Long?

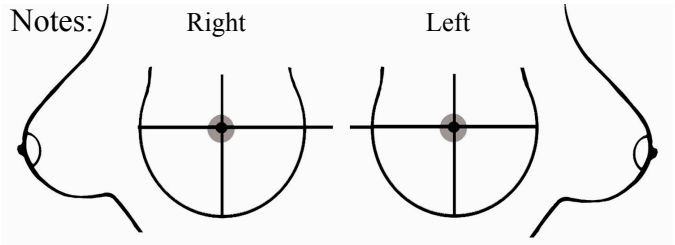
❒ Estrogen/Progestrone _____
❒ Fertility Drugs _____
❒ Birth Control _____
❒ Other_____

If you plan to return to AMI for future mammograms, please sign below.
This will authorize AMI to keep your mammogram films.

_____
(Signature)

**** Physician Notes ONLY ****

Notes:



Please check this box if the patient is recommended for risk assessment ☐

Technologist Signature