** MAMMOGRAPHY PATIENT**

 **HISTORY QUESTIONNAIRE**

 **Female**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Have you ever had any prior breast imaging (Mammogram, Breast Ultrasound or Breast MRI)? ❑ No ❑ Yes

If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If it was done under a different name, what name? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the reason for this visit? ❑ Routine ❑ Problem (explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last breast clinical exam by your doctor’s office: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a **personal** history of breast or ovarian cancer? ❑ No ❑ Yes ❑ Breast ❑ Ovarian

 If yes, at what age were you diagnosed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had any of the following breast procedures? (Check all that apply)

❑ Breast Biopsy ❑ Right ❑ Left ❑ Bilateral

❑ Reduction ❑ Right ❑ Left ❑ Bilateral

❑ Implants ❑ Right ❑ Left ❑ Bilateral

 ❑ Mastectomy ❑ Right ❑ Left ❑ Bilateral

❑ Lumpectomy ❑ Right ❑ Left ❑ Bilateral

❑ Radiation Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ Chemotherapy Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a **family** history of breast or ovarian cancer: ❑ No ❑ Yes

If yes, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was their age at diagnosis? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take any hormones: ❑No ❑ Yes If yes, for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age at first period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been pregnant? ❑No ❑ Yes If yes, age at your first pregnancy? ­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently pregnant? ❑No ❑ Yes or Breastfeeding? ❑No ❑ Yes

Are you Postmenopausal? ❑No ❑ Yes If yes, age at menopause: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_