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Mammography Questionnaire

Name: [ ] Date: [ ]
Date of Birth: [ ] Ethnicity: [ ]
Phone Number: [ ]

1. Is this a: Routine Screen Mammogram ( ) Yes ( ) No
   Diagnostic Mammogram ( ) Yes ( ) No
   Ultrasound Only ( ) Yes ( ) No

2. Do you have any concerns about your breasts today (i.e. lump, pain, discharge)?

3. Have you ever had **any surgery** on your breasts? ( ) Yes ( ) No

4. Do you have **breast implants**? ( ) Yes ( ) No
   ( ) Saline ( ) Silicone

5. Have you ever had a **lumpectomy for cancer**? ( ) Yes ( ) No ( ) Year
   If yes, have you had *radiation treatment* ? ( ) Right ( ) Left
   If yes, have you had *chemotherapy* ? ( ) Yes ( ) No

6. Have you ever had a **masectomy for cancer**? ( ) Yes ( ) No ( ) Year
   If yes, have you had chemotherapy? ( ) Right ( ) Left

7. Have you had a **benign** biopsy / lumpectomy? ( ) Yes ( ) No ( ) Year
   ( ) Right ( ) Left

8. Have you had a **breast reduction**? ( ) Yes ( ) No

9. Do you take: ( ) Hormone Therapy For how long? [ ]
   ( ) Birth Control ( ) Blood Pressure Medication

10. Do you have any family history of **breast cancer**? If so, **who** and at **what age** were they diagnosed

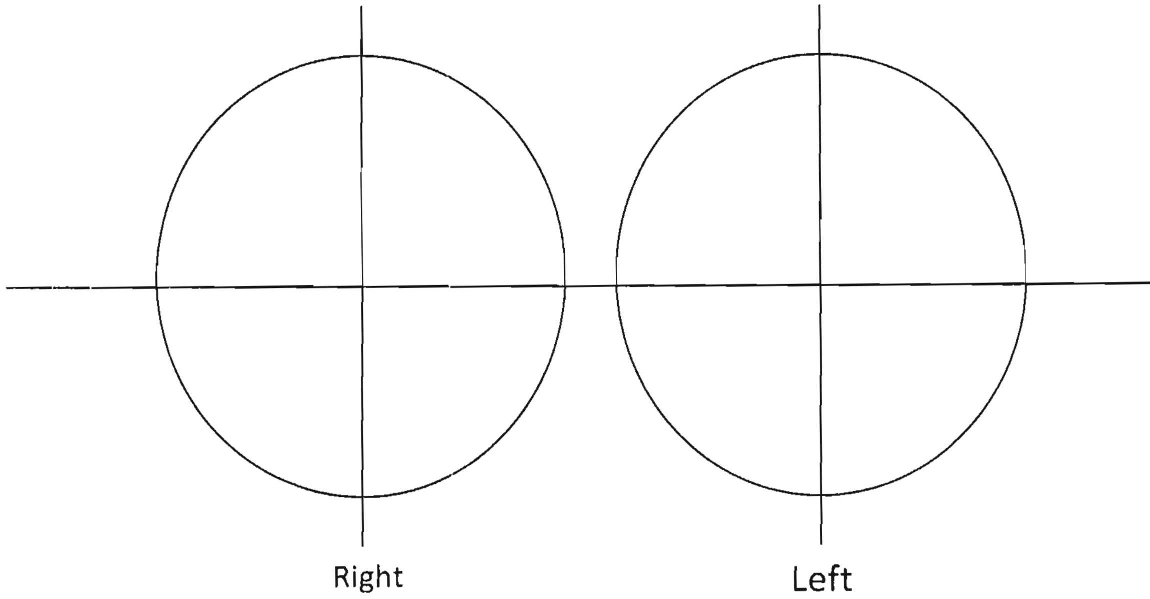
11. Is there any personal or family history of **ovarian cancer**? If yes, **who** and at **what age** were they diagnosed?

12. Have you ever had a **previous mammogram**?
    If yes, When: [ ] Where: [ ]

13. Have you ever had a **breast MRI**?
    If yes, When: [ ] Where: [ ]

14. Is there any chance you may be **pregnant**? ( ) Yes ( ) No

Ultrasound Technologist's Worksheet



Findings:

Right Breast: ____________________

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Left Breast: ____________________

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Technologist's Notes: ______________________________

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