Covid Vac:

GNMI MEDICAL IMAGING

MAMMOGRAM QUESTIONAIRE

Name: _____

Date: _____ Age: _____ Ethnicity: _____

Previous mammogram: yes / no If yes, when: _____

Where: _____

Date/Age of LAST period: _____ Age at FIRST period: _____

Had a hysterectomy and what age: _____ Ovaries removed: yes / no right / left / both

Weight change in PAST YEAR: Gain / Lost How much: _____ lbs

How many children: _____ How many pregnancies: _____ Age YOU were at FIRST live birth: _____

Have YOU had breast cancer: yes / no If yes: Right / Left / Both

Have YOU had ovarian cancer: yes / no If yes: Right / Left / Both

Have YOU had any other cancers: yes / no

Have a relative with breast or ovarian cancer: yes / no Relative: _____ What age was the relative diagnosed: _____

Taking any hormones or birth control: yes / no How long: _____

List of hormones or birth control: _____

Have you had surgery or a biopsy to your breast: yes / no When: _____
Which breast: right / left / both Cyst aspiration: ___ Surgical biopsy _____ Needle biopsy _____
Mastectomy _____ Lumpectomy _____ Implants _____ Other: _____

Any trauma to the breast: _____

Any previous radiation to the chest: yes / no

Any problems with your breasts NOW: yes / no How long: _____

Lump: _____ Discharge: ____Type of Discharge: _____

Pain: _____ Dimpling _____ Redness_____ Inverted Nipple_____ Other: _____

Breast Disease: _____

Technologist Signature: _____

OFFICE USE ONLY:

Risk of implant rupture discussed with patient: _____(tech)_____(pt)