the WOMAN'S IMAGING group

MAMMO PATIENT HISTORY AND QUESTIONNAIRE

DATE: _____ NAME: _____ D.O.B: _____

REFERRING DR: _____ DOCTOR'S PHONE NUMBER: _____

HAVE YOU EVER HAD A MAMMOGRAM? YES NO

IF YES,

FACILITY NAME: _____ DATE OF LAST MAMMOGRAM: _____

FACILITY PHONE: _____ FACILITY ADDRESS: _____

DATE OF LAST PHYSICAL BREAST EXAM BY YOUR DOCTOR: _____

PERSONAL HISTORY

HAVE YOU HAD ANY OF THE FOLLOWING? (CIRCLE YES OR NO AND INDICATE RT OR LT)

- BIOPSY YES / NO RT / LT DATE: _____
- MASTECTOMY YES / NO RT / LT DATE: _____
- BREAST CANCER YES / NO RT / LT DATE: _____
- IMPLANTS YES / NO RT / LT DATE: _____
- REDUCTION YES / NO RT / LT DATE: _____
- HYSTERECTOMY YES / NO COMPLETE/PARTIAL DATE: _____
- HORMONE THERAPY YES / NO TYPE: _____ HOW LONG? _____

AGE AT 1ST MENSTRUATION: _____ LAST MENSTRUAL PERIOD or AGE OF MENOPAUSE: _____

 # OF PREGNANCIES: _____ # OF BIRTHS: _____ AGE AT 1ST PREG: _____

FAMILY HISTORY

HAS ANYONE IN YOUR FAMILY BEEN DIAGNOSED WITH BREAST CANCER? IF YES, PLEASE INDICATE WHO AND AGE AT WHICH THEY WERE DIAGNOSED.

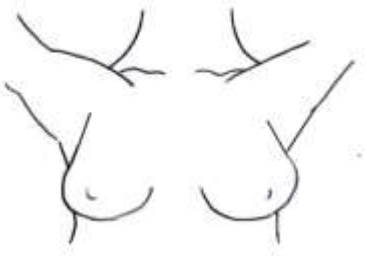
MOTHER- AGE OF DIAGNOSIS _____ DAUGHTER- AGE OF DIAGNOSIS_____

SISTER- AGE OF DIAGNOSIS _____ MATERNAL GRANDMOTHER- AGE OF DIAGNOSIS _____

MATERNAL AUNT- AGE OF DIAGNOSIS _____

PATIENT'S SIGNATURE: _____ DATE: _____

(DO NOT WRITE BELOW LINE. TECHNOLOGIST USE ONLY)



Technologist Notes: _____

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PRIORS REQUESTED: YES NO DATE REQUESTED: _____

Technologist Signature: _____