Hunterdon Radiology Associates

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Mammography Patient Questionnaire

(PLEASE ANSWER ALL QUESTIONS AND UPDATE ANY NEW INFORMATION)

DATE: _____

NAME:	PT ID#:	DOB:	AGE:
ADDRESS:			
HOME PHONE:	WORK PHONE:	REFERRING PHYSICIAN:	EXAM DATE:

REASON FOR EXAM PLEASE DESCRIBE ANY PROBLEMS YOU ARE HAVING WITH YOUR BREASTS:

_____

_____

PREVIOUS MAMMOGRAMS IS THIS YOUR FIRST MAMMOGRAM? YES NO IF NO, WHEN AND WHERE HAVE YOU HAD A MAMMOGRAM?

_____

_____

MEDICAL HISTORY AGE AT HYSTERECTOMY AND/OR OVARY(S) REMOVED, IF ANY:

_____

NUMBER OF PREGNANCIES: _____ DATE OF LAST PERIOD: ___/___/___

NUMBER OF DELIVERIES: _____ AGE AT FIRST PERIOD: _____

AGE AT FIRST DELIVERY: _____ AGE AT MENOPAUSE: _____

ORAL CONTRACEPTIVE USE

_____

_____

_____

NUMBER OF MONTHS OF USE: _____

PERSONAL HISTORY

HAVE YOU HAD BREAST CANCER? _____

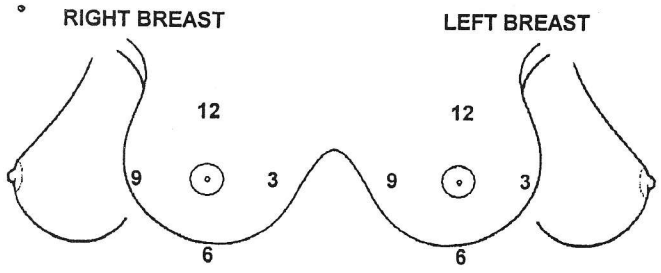
IF YES, PLEASE DESCRIBE: _____

HAVE YOU HAD NON-BREAST CANCER? _____

IF YES, PLEASE DESCRIBE: _____

PLEASE INDICATE THE DATE AND SIDE OF EACH OF THE FOLLOWING: MASTECTOMY, LUMPECTOMY, BIOPSY, RADIATION THERAPY, BREAST RECONSTRUCTION, BREAST IMPLANTS AND BREAST REDUCTION:

PROCEDURE	SIDE	DATE



FAMILY HISTORY

HAS ANY BLOOD RELATIVE HAD BREAST CANCER? YES NO IF YES, PLEASE LIST EACH & THEIR RELATIONSHIP TO YOU:

_____

HAS ANY BLOOD RELATIVE HAD NON-BREAST CANCER? YES NO IF YES, PLEASE LIST EACH & THEIR RELATIONSHIP TO YOU:

HORMONE USE TYPE / AGE AT FIRST USE / NO. OF MONTHS OF USE:

IMPLANTS

COMMENTS

_____

_____

SIGNATURE

I ATTEST THAT THE INFORMATION I HAVE PROVIDED ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE.

_____ _____ _____

SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO CONSENT FOR PATIENT DATE TECHNOLOGIST