THE BREAST CENTER
St. David's Medical Center

MAMMOGRAPHY QUESTIONNAIRE

Please fill out the questions below as completely as possible. Thank you for choosing St. David's!

Last Name _____ First Name _____ Date of Birth _____

Send Reports to Dr (s):_____

EXAM(S) TO BE DONE TODAY: ☐ **Digital Mammogram** ☐ **Digital w/ 3-D TOMO** ☐ **Ultrasound** ☐ **Bone Density**

☐ **Yes** ☐ **No** **HAVE YOU HAD A PREVIOUS MAMMOGRAM(S)? Date and Location** _____

How did you hear about The Breast Center? ☐ Physician ☐ Friend/Family ☐ Interenet/Website ☐ TV/Meda ☐ Other

CURRENT HISTORY:

☐ Yes ☐ No Are you pregnant? Last Menstrual period? _____ Age of 1st menstrual period? _____

☐ Yes ☐ No Are you currently breast-feeding? Age at first Full-Term pregnancy _____

☐ Yes ☐ No Do you use hormones now? Any changes over the last 6 months?

If yes, please explain_____

☐ Yes ☐ No Have you had a recent breast exam by your physician/practioner? When? _____

☐ Yes ☐ No **Any NEW lumps in your breast?** ☐ **Lt** ☐ **Rt**

☐ Yes ☐ No **Any discharge from nipple?** ☐ **Lt** ☐ **Rt**

☐ Yes ☐ No **Any soreness of breast?** ☐ **Lt** ☐ **Rt**

☐ Yes ☐ No **Other changes?** ☐ **Lt** ☐ **Rt** **Explain:** _____

PERSONAL HISTORY:

☐ Yes ☐ No Have you ever had cancer? If yes, what type? _____

☐ Yes ☐ No History of **Breast or Ovarian** cancer in the family? (If yes, please complete check box below.)

	Breast Cancer at or before age 50	**Ovarian cancer at any age**
Self		
Mother		
Sister		
Daughter		
Maternal Grandmother		
Maternal Aunt		
Paternal Grandmother		
Paternal Aunt		
2 or more cases of breast cancer (after age 50) on the same side of the familiy		
Male breast cancer in any relative		
Jewish Ancestry		

☐ Yes ☐ No Have you ever had previous breast surgery?

If yes, please check the following boxes:	**Which Breast?**	**Date of procedure:**	**Result** (positive or negative)
☐ Aspiration	☐ Lt ☐ Rt	_____	_____
☐ Biopsy	☐ Lt ☐ Rt	_____	_____
☐ Mastectomy	☐ Lt ☐ Rt	_____	_____
☐ Lumpectomy (for breast cancer)	☐ Lt ☐ Rt	_____	_____
☐ Reduction	☐ Lt ☐ Rt	_____	_____
☐ Implants	☐ Lt ☐ Rt	_____	_____
☐ Rad. Therapy	☐ Lt ☐ Rt	_____	_____
☐ Reconstruction	☐ Lt ☐ Rt	_____	_____

Have you ever had: **Genetic Counseling/Testing** ☐ Yes ☐ No **Results Positive?** ☐ Yes ☐ No **Date of Test**_____

I give permission for St. David's Breast Center to obtain my prior mammogram/ultrasound films. I also authorize St. David's to obtain any medical reports pertinent to my care.

Patient Signature _____ Date _____

Please do not write below this line.

☐ **Postive: meets criteria** ☐ **Negative per criteria**

Technologist Name: _____

☐ Mammogram handout given ☐ Machine disenfected prior to exam