

# DIGITAL MAMMOGRAPHY QUESTIONNAIRE

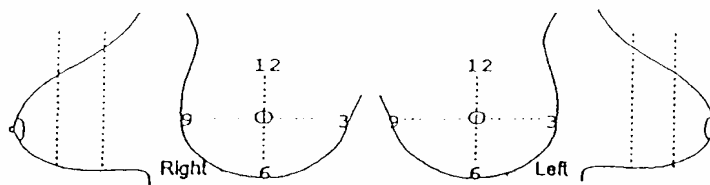
Name: \_\_\_\_\_ Age: \_\_\_\_\_  
(Last) (First) (M)

- 1) Have you had children?  Yes  No
- 2) A) Any possibility of pregnancy?  Yes  No  
B) Date of Last Menstrual Period \_\_\_\_\_  
C) Have you begun or have you had your menopause?  Yes  No
- 3) Has your doctor examined your breasts in the last two months?  Yes  No  
**Findings:** \_\_\_\_\_
- 4) Has any member of your family had breast cancer?  Yes  No  
If so, whom? \_\_\_\_\_
- 5) Have you had cancer of the breast?  Yes  No  
If yes, when was it diagnosed? \_\_\_\_\_ Surgery? \_\_\_\_\_ Radiation? \_\_\_\_\_
- 6) Check if you have had any Personal History of cancer:  Endometrial (uterus)  Ovarian  Colon  
 Other \_\_\_\_\_
- 7) Please list any breast surgery: \_\_\_\_\_ Do you have implants?  Yes  No
- 8) Please list any other breast problems: \_\_\_\_\_
- 9) Are you taking any hormones, menopause, osteoporosis or birth control pills?  Yes  No  
If so, what? \_\_\_\_\_
- 10) Have you had a previous mammogram?  Yes  No  
If yes: Where? \_\_\_\_\_ When? \_\_\_\_\_
- 11) Which of the following is the reason for having this mammogram?  
 Baseline (1<sup>st</sup> Mammogram-No Symptoms)  
 Screening (No Symptoms)  
 Lump ~ Where? \_\_\_\_\_ How long has it been present? \_\_\_\_\_  
Can you feel it?  Yes  No Can your doctor feel it?  Yes  No  
 Discharge ~ which side? \_\_\_\_\_ What color? \_\_\_\_\_  
 Pain ~ which side? \_\_\_\_\_  
 Change in appearance of your breast? Describe: \_\_\_\_\_  
 Other ~ Describe: \_\_\_\_\_

**FOR TECHNOLOGIST USE ONLY**  
**↓ DO NOT WRITE BELOW THIS LINE ↓**

Date: \_\_\_\_\_ X-ray Number: \_\_\_\_\_ Radiologist who checked  
Diagnostic Exam: \_\_\_\_\_

History/Clinical Symptoms:



**Remember to DICTATE Bi-Rads Code**

Technologist \_\_\_\_\_