

The Breast Clinic Mammography Questionnaire

Sandra L. Hanson, M.D.

Today's Date: _____ Patient Name: _____ Age: _____

Referring Physician: _____ City/State: _____

Have you ever had a Mammogram? Yes No If yes, where? _____ When? _____ Did you bring films? Yes No

Date of last Colonoscopy? _____ Date of last Bone Density? _____

Has anyone in your family been diagnosed with breast cancer? Yes No If yes, please indicate below their relationship to you:

BREAST CANCER

MOTHER'S SIDE: Mother Daughter Sister
 Grandmother Aunt Cousin
FATHER'S SIDE: Grandmother Aunt Cousin

OVARIAN CANCER

Mother Daughter Sister
 Grandmother Aunt Cousin
 Grandmother Aunt Cousin

Has anyone been tested for BRCA? Yes No If yes, when? _____

Have you ever been diagnosed with breast cancer? Yes No If yes, when? _____

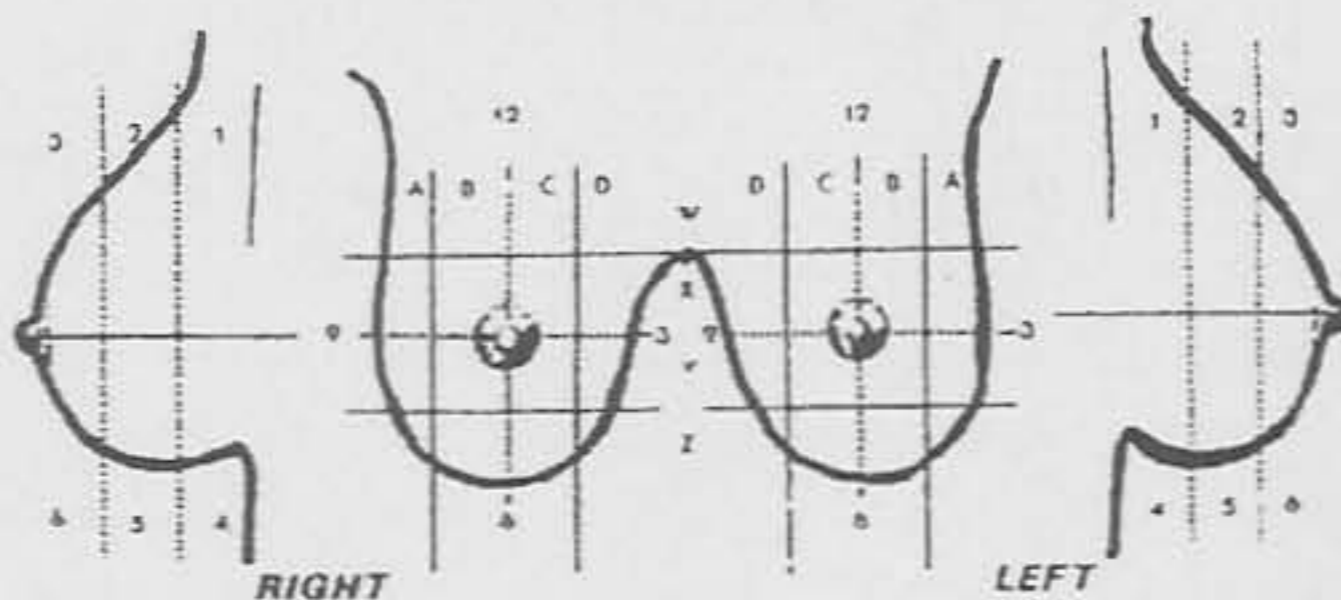
Chemotherapy (for breast cancer) Yes No

Radiation Therapy (for breast cancer) Yes No

CURRENT PROBLEMS

- LUMP Left Right
- PAIN Left Right
- FULLNESS Left Right
- DISCHARGE Left Right
- Color: _____
- RASH Left Right
- NIPPLES Left Right
- TRAUMA Left Right

MARK AREA OF CONCERN



PREVIOUS BREAST PROCEDURES

- BIOPSY Left Right When? _____
- Findings: _____
- IMPLANTS Saline Silicone When? _____
- REDUCTION When? _____
- MASTECTOMY Left Right When? _____
- LUMPECTOMY Left Right When? _____
- CYST ASPIRATION Left Right
- When? _____
- CYST REMOVAL Left Right When? _____

Describe: _____

OTHER: _____

Have you had a hysterectomy? Yes No If yes, Abdominal Vaginal

If ovaries removed, when? _____ Why? _____

If uterus removed, when? _____ Why? _____

Are you taking hormones? Yes No

Steroids? Yes No

Birth Control Pills? Yes No

Are you pregnant? Yes No Have you ever been pregnant? Yes No If yes, number of pregnancies: _____ Number of children: _____

Your age at your first pregnancy? _____ Did you breast feed? Yes No If yes, how long? _____

Your age at your first menstrual period? _____ When was your last menstrual cycle? Month _____ Year _____

Do you smoke? Yes No _____ # of cigarettes a day. If quit, how long ago? _____ (CONGRATULATIONS)

Do you drink alcohol? Never On average: 1-2 per week 5 drinks per week 10 drinks per week 1-2 a month Quit - how long? _____

What is your caffeine intake per day? Coke _____ Tea _____ Coffee _____ Chocolate _____

Have you ever had any cancer not related to the breast? Yes No What type? _____ When? _____

Radiation treatment? _____ Chemotherapy? _____

I hereby authorize the release of any and all information related to the follow-up on mammography examination dated _____ to The Breast Clinic, Inc.

Authorized by: **X** _____ Date: _____