

RADIOLOGY ASSOCIATES

MAMMOGRAPHY QUESTIONNAIRE

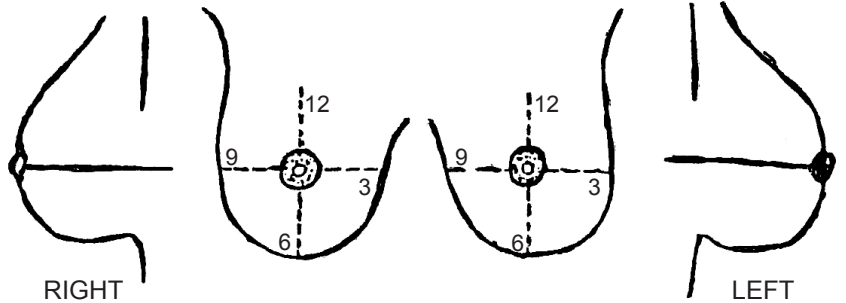
Patient Name: _____ Date of Birth: _____ Age: _____
 Physician: _____

Is this your first mammogram? YES NO If NO, when was your last mammogram? _____
 Name & address of the clinic where you had your last mammogram: _____

➔ To authorize transfer of your records, please complete the form on the back. ➔

BREAST HEALTH: If you are having any new problems with your breasts, please mark the symptoms in this section:

- Lump or Thickening RT LT
- Pain or Tenderness RT LT
- Nipple Discharge RT LT
- Nipple Abnormality RT LT
- Large Lymph Nodes RT LT
- Infection or Inflammation RT LT
- Recent Breast Injury RT LT
- Discharge Color _____
- Fibrocystic Change RT LT
- Other _____



How long have you had these symptoms? _____

BREAST CANCER: Have you had breast cancer? YES NO

1. If YES, which breast? RT LT When were you diagnosed? _____
2. If YES, please mark which treatments you have had done:
 - Lumpectomy RT LT Mastectomy RT LT
 - Radiation RT LT Chemotherapy RT LT Tamoxifen or Evista? YES NO
 - Reconstruction RT LT Type of reconstruction: _____

IMPLANTS: Do you have implants? YES NO 1. YES, RT LT 2. Type: Saline Silicone Don't know

PROCEDURES: Please mark any of the following procedures you have had done.

- Breast MRI RT LT
- Needle biopsy RT LT
- Cyst aspiration RT LT
- Surgical biopsy RT LT
- Breast reduction RT LT
- Date _____

FAMILY HISTORY: Has anyone in your family had breast cancer? YES NO

If yes, please check below and give age when diagnosed

- Mother _____
- Sister _____
- Daughter _____
- Aunt _____
- Niece _____
- Female Cousin _____
- Grandmother _____
- Father
- Son
- Brother
- Grandfather
- Uncle
- Nephew
- Male cousin

OVARIAN CANCER: Have you had ovarian cancer? YES NO If YES, when were you diagnosed? _____
 2. Has anyone in your family had ovarian cancer? YES NO If YES, specify: _____

GYNECOLOGICAL HISTORY: Please answer the following that apply to you.

1. Are you pregnant? YES NO Don't know
2. If you are still having periods, when was your last one? _____
3. If not, have you gone through menopause? YES NO Don't know If yes, age: _____
4. Have you had a hysterectomy? YES NO If yes, ovaries removed? YES NO Age: _____
5. Are you currently taking hormone or birth control pills? YES NO Name of hormone/birth control: _____
6. If no, have you ever taken them YES NO When did you stop taking them? _____
7. How many times have you been pregnant? _____ How many live births have you had? _____
8. Your age when you delivered 1st live birth? _____ Age at last live birth? _____



Date of Last Mammogram and Facility if not here: _____

- If your previous mammograms are not with *Radiology Associates*, it is most important for us to obtain your prior study for comparative interpretation by our Radiologist. By providing the information and signing below, we will do this for you.

_____ Your Name at time of Exam

SS# _____ DOB _____

_____ Your Daytime Phone Number

_____ Doctor who received the Report

- **Radiology Associates of Tarrant County correlates all abnormal mammograms with pathology reports resulting from biopsy. By signing below, I am authorizing release of information of these reports and information pertaining to them from my Healthcare Provider or his/her Associate, or any Facility performing a breast biopsy or procedure.**
- Mammography is done with a special x-ray machine that requires compression of the breast tissue. Although rare, a defective or old implant may deflate or rupture in patients who have had Breast Augmentation (Breast Implants).
- Although Mammography is the most reliable method of detecting breast cancer while it is still early and too small to be felt, a mammogram does not detect 100% of breast cancers. Some cancers may be detected only on physical examination and/or breast self-examination.
- If you think you may be pregnant, please inform the Mammographer.
- I understand that the examination I am having involves radiation and that radiation may cause injury to an unborn fetus, although the likelihood of such injury is slight. My Physician feels that the information to be gained from the examination is important to my health, and I therefore wish to have the X-Rays and/or scan performed.

Signature of Patient

Date

For Registered Mammographer Notes Only:

Mammographer

