McLaren THUMB REGION

1100 S. Van Dyke
Bad Axe, Michigan

Mammogram -Questionnaire

To be filled out by the patient

Note: If there is deodorant or powder on your breast or on your underarms, please wash it off before you have the mammogram. Ask the technologist for help if you need it.

Name: ________________ Date of Birth: ____________ Age: ____________

Referring Physician________________ Today's Date: ____________

Yes No 1. Have you had a mammogram before? When________________

Where________________

Yes No 2. Do you practice self-examinations of the breasts monthly?

Yes No 3. Have you had a child? Your age at 1st birth ____________

Yes No 4. Have any of the following family members had **BREAST CANCER**?

________Mother She was ____________ years old when it was found

________Sister She was ____________ years old when it was found

________Daughter She was ____________ years old when it was found

________Grandmother She was ____________ years old when it was found

________Aunt She was ____________ years old when it was found

________Cousin She was ____________ years old when it was found

Yes No 5. Are you pregnant?

6. Age of Menopause __________

Yes No 7. Are you taking hormones: (Estrogen, Premarin, Provera, Tamoxifen)
Name of hormone ________________

Yes No 8. Have you gain or lost weight since your last mammogram?
I have gained__________pounds or lost __________pounds

Yes No 9. Have you ever had any type of cancer? What type________________

When was it found? ____________

Yes No 10. Have you ever had breast surgery?

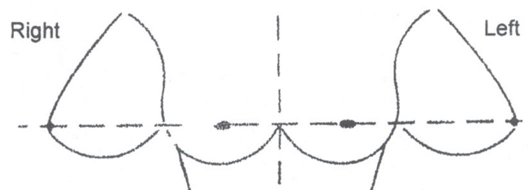
_____Biopsy	Rt._____	Lt._______	When? __________	Diagnosis? __________
_____Mastectomy	Rt._____	Lt._______	When? __________	Diagnosis? __________
_____Lumpectomy	Rt._____	Lt._______	When? __________	Diagnosis? __________
_____Reduction	Rt._____	Lt._______	When? __________	Diagnosis? __________
_____Breast implant	Rt._____	Lt._______	When? __________	Diagnosis? __________
_____Cyst aspiration	Rt._____	Lt._______	When? __________	Diagnosis? __________

Yes No 11. Have you had radiation therapy or chemotherapy for breast cancer?
When was your last treatment?________________

Yes No 12. Are you having problems with either breast?
Explain________________

To be filled out by the Technologist

Check: Breast surface (including medial, inferior)
Nipples inverted? Discharge? How long? ____________
Breast size discrepancy Which: ____________



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