Digital
Mammogram Questionnaire

Date _____

Name _____ Age _____ Physician _____

Phone No. _____ Work No. _____

Have you ever had a Mammogram before? yes no

Where? _____

Do you presently have any of the following symptoms?

Pain/Tenderness	yes	no	If yes, which breast	R	L
Lump	yes	no	If yes, which breast	R	L
Nipple Discharge	yes	no	If yes, which breast	R	L

Family History

Has any blood relative had breast cancer? yes no

(Circle below)

Mother Sister Daughter At What Age? _____

Grandmother - Paternal/Maternal

Aunt - Paternal/Maternal

Personal History

Are you taking birth control/hormones? yes no

If yes, what are you taking? _____ How long? _____

Have you ever had cancer? yes no

If yes, what kind _____

Have you ever had breast surgery? yes no

If yes,	Mastectomy	R / L	Year _____
	Biopsy	R / L	Year _____
	Aspiration	R / L	Year _____
	Implants	R / L	Year _____
	Other	R / L	Year _____

Menstrual History

Age Started Menses _____

Age Ended Menses _____

Last Period _____

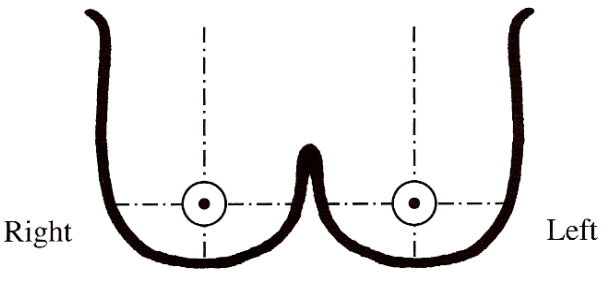
Technologist _____

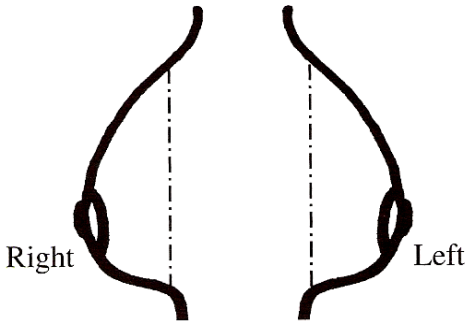
Childbirth History

No. of pregnancies _____

Age at first pregnancy _____

Comments _____





MAUI DIAGNOSTIC IMAGING

Equipment has been cleaned prior to patient use by Technologist : _____