Texas Health Presbyterian Hospital FLOWER MOUND

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Flower Mound, TX 75028
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MAMMOGRAPHY PATIENT QUESTIONNAIRE

TODAY'S DATE:_____

NAME:	HOME PHONE:	CELL PHONE:	DOB:	AGE:

All replies are confidential. Check 'Yes' or 'No' and answer all questions.

PREVIOUS MAMMOGRAMS

YES ☐ **NO** ☐ HAVE YOU HAD A MAMMOGRAM BEFORE? IF YES. INDICATE WHEN, THE NAME OF THE FACILITY AND WHETHER THE FILMS ARE STILL THERE.

_____

_____

LAST BREAST EXAM BY A PHYSICIAN OR A PHYSICIAN'S ASSISTANT WAS _____

PERSONAL HISTORY

YES ☐ **NO** ☐ HAVE YOU HAD BREAST CANCER? IF YES, INDICATE WHICH BREAST, WHAT YEAR DIAGNOSED, WHETHER YOU RECEIVED RADIATION TREATMENT, WHAT YEAR YOU COMPLETED TREATMENT AND WHETHER YOU HAD A MASTECTOMY.

_____

FAMILY HISTORY

YES ☐ **NO** ☐ ANY FAMILY HISTORY OF BREAST CANCER? IF YES, INDICATE EACH RELATIVE, THEIR AGE AND WHETHER IT WAS BEFORE MENOPAUSE.

_____

BREAST PROBLEMS

YES ☐ **NO** ☐ PLEASE STATE THE REASON YOU ARE HAVING THIS EXAM AND INDICATE ANY PROBLEMS YOU ARE HAVING WITH YOUR BREASTS:

_____

_____

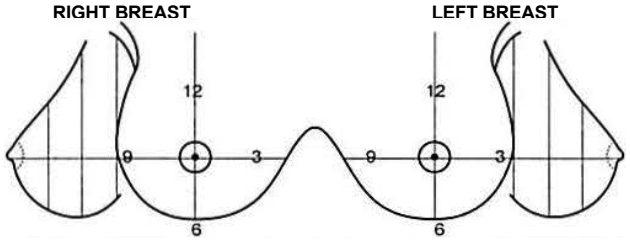
LEFT	RIGHT		LEFT	RIGHT		LEFT	RIGHT		LEFT	RIGHT		LEFT	RIGHT	
☐	☐	LUMP / PALP ABNORM	☐	☐	PAIN	☐	☐	NIPPLE ABNORM	☐	☐	BLOODY DISCHARGE	☐	☐	NON-BLOODY DISCHARGE

PRIOR BREAST SURGERIES

YES ☐ **NO** ☐ HAVE YOU HAD PREVIOUS BREAST SURGERY, BIOPSY, NEEDLE ASPIRATION OR REDUCTION? IF YES, INDICATE WHICH BREAST, APPROXIMATE DATES AND, IF BIOPSY, WHAT THE DIAGNOSIS WAS.

PROCEDURE	SIDE	YEAR
_____	_____	_____
_____	_____	_____

PLEASE MARK ON THE DIAGRAM WHERE YOUR PROBLEM IS:



IMPLANTS

YES ☐ **NO** ☐ DO YOU HAVE BREAST IMPLANTS NOW OR HAVE YOU HAD ANY IMPLANTS IN THE PAST? IF YES, WHEN?

BIRTH CONTROL

YES ☐ **NO** ☐ TYPE OF BIRTH CONTROL:_____

HORMONE USE

YES ☐ **NO** ☐ TYPE / AGE AT FIRST USE / NO. OF MONTHS OF USE:

PREGNANT?

YES ☐ **NO** ☐ ARE YOU PREGNANT AT THIS TIME OR IS THERE ANY CHANCE YOU COULD BE PREGNANT?: NO. OF WEEKS PREGNANT:_____

ETHNICITY CAUCASIAN ☐ AFRICAN-AMERICAN ☐ ASIAN-AMERICAN ☐ HISPANIC ☐ OTHER ☐

MEDICAL HISTORY

AGE AT FIRST PERIOD: _____ DATE OF LAST PERIOD: _____ AGE AT MENOPAUSE: _____

NUMBER OF DELIVERIES: _____ AGE AT FIRST DELIVERY: _____

PRIMARY REFERRING PHYSICIAN:	PHONE:	2ND REFERRING PHYSICIAN:	PHONE:

COMMENTS _____

_____ _____ _____

SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO CONSENT FOR PATIENT | DATE | TECHNOLOGIST