Texas Health Presbyterian Hospital®
FLOWER MOUND

Male Mammography Patient Questionnaire

TODAY'S DATE: _____

2560 Central Park Avenue, Suite 240
Flower Mound, TX 75028
469-322-7729

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:

_____

_____

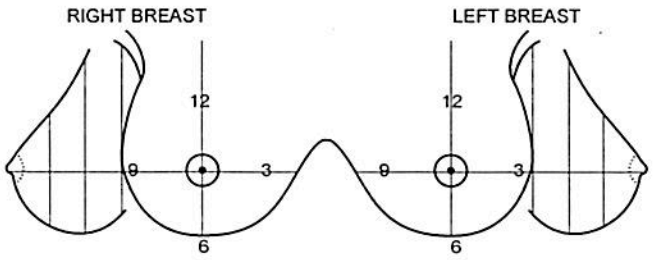
LEFT	RIGHT		LEFT	RIGHT		LEFT	RIGHT		LEFT	RIGHT		LEFT	RIGHT	
☐	☐	LUMP / PALP ABNORM	☐	☐	PAIN	☐	☐	NIPPLE ABNORM	☐	☐	BLOODY DISCHARGE	☐	☐	NON-BLOODY DISCHARGE

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:



MEDICATIONS

_____

_____

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

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

COMMENTS _____

_____ _____ _____

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