St Joseph's Healthcare System

St. Joseph's Regional Medical Center
St. Joseph's Wayne Hospital
A Division of St. Joseph's Regional Medical Center
St. Vincent's Nursing Home

PATIENT ID HERE

DEPARTMENT OF RADIOLOGY

MAMMOGRAM QUESTIONAIRE

TO BE FILLED OUT BY THE PATIENT:

Name: ______________________________ DOB: ________

Date: ____________________ Physician: ______________________________

Have you had a mammogram before? ___No ___Yes

If YES, where ______________________________ when ____________

I understand that I have been asked to bring in any previous mammograms: ___No ___Yes

Is this mammogram routine? ___No ___Yes

Reason for mammogram? ______________________________

____

Is there a history of breast cancer in your family? ___No ___Yes

If YES, please indicate who developed breast cancer. At what age did cancer develop?

Myself_____ Mother_____ Sister_____ Grandmother_____ Other_____

Do you have breast implants? ___No ___Yes If YES, circle one: Saline or Silicone

Date of last menstrual period ____________

Are you pregnant or is there any possibility you may be pregnant? ___No ___Yes

Number of pregnancies___ Number of children___ Your age at first birth___

Do you or have you used hormones? (Estrogen, Premarin, Provera, Tamoxifen, any others): ___No ___Yes

If YES, which type? ____________ How long? ____________ Still using? ____________

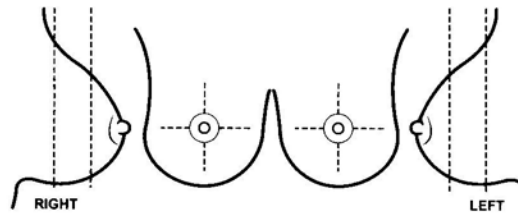
Have you breast fed within the past 3 months? ___No ___Yes

Have you had a weight change of more than 10 pounds in the last year? ___No ___Yes

Have you ever had a trauma to your breast to cause black and blue marks? ___No ___Yes

Patient's Signature▶ ______________________________

TO BE FILLED OUT BY TECHNOLOGIST:



Appearance of Breast Physical Examination

Lesion growths	R	L
Moles	R	L
Scars	R	L
Lumps	R	L

Patient MR#: ____________________

Check: Breast Surface (including medial, inferior)_____ Nipples inverted?_____ Discharge?_____

Size discrepancy?_____ Which?_____ Implants?_____ (circle one) Saline or Silicone

Last clinical breast palpation: ____________________ By Whom: ____________________

History of breast surgery or aspirations: (reason, location, date) ______________________________

____

Radiation treatment? Started ____________________ Finished ____________________

Chemotherapy treatment? Started ____________________ Finished ____________________

Reason for added view: ______________________________

Comments: ______________________________

____

______________________________ Tech: ____________________

Equipment cleaned and/or disinfected prior to procedure?_____(Please check if done)

Technologist's Signature▶ ______________________________