ARYA STANA
BONE & BREAST CARE

MAMMOGRAPHY QUESTIONNAIRE

PATIENT TO COMPLETE

Date _____ **Referring Doctor** _____

Name _____ DOB _____ Age _____

Previous Mammogram ☐ Yes ☐ No Date: _____ Location _____ Date of last breast exam by a doctor _____

Are you currently pregnant or trying to conceive? ☐Yes ☐ No Number of live births ___ Age at 1st Pregnancy ___Are you breast feeding? ☐Yes ☐No

Are you on Fertility Treatment? ☐ Yes ☐ No

Date of Last Menstruation. _____ Age Menstruation Began _____ Menopausal Status Pre / Peri / Post Age began_____

Do you exercise regularly? ☐Yes ☐ No

Do you smoke? ☐ Yes ☐ No

Alcohol consumption: Nil / Mild / moderate / heavy

Hysterectomy ☐ Yes ☐ No

Ovaries removed ☐ Yes ☐ No

Do you have any new breast problems?

☐ No - or -

☐ Lump ☐ Right ☐ Left
☐ Pain ☐ Right ☐ Left
☐ Nipple discharge ☐ Right ☐ Left
☐ Trauma ☐ Right ☐ Left
☐ Other – please describe _____

Have you had any of the following?

☐ No - or -

☐ Breast Reduction ☐ Right Year _____ ☐ Left Year _____
☐ Cyst drained ☐ Right Year _____ ☐ Left Year _____
☐ Surgical Biopsy ☐ Right Year _____ ☐ Left Year _____
☐ Fine Needle/Core biopsy ☐ Right Year _____ ☐ Left Year _____
☐ Lumpectomy - Benign or Malignant ☐ Right Year _____ ☐ Left Year _____
☐ Other Breast Surgery ☐ Right Year _____ ☐ Left Year _____
☐ Mastectomy ☐ Right Year _____ ☐ Left Year _____
☐ Chemo/Radiation for breast cancer
☐ Implants ☐ Right Year _____ ☐ Left Year _____
Have they been replaced? ☐ N ☐ Y If yes Date _____
Type ☐ Silicone ☐ Saline ☐ Other _____
Location ☐ Subglandular (Under skin)
☐ Subpectoral (Under muscle)

Are you currently taking hormones for birth control or menopause?

☐ No - or -

☐ Yes. Date started _____ Date stopped_____
Type_____

Have you or a family member had a history of breast cancer?

☐ No - or -

☐ Self Age at diagnosis _____
☐ Mother Age at diagnosis _____
☐ Sister Age at diagnosis _____
☐ Daughter Age at diagnosis _____
☐ Grandmother Age at diagnosis _____ ☐ Mother's side ☐ Father's side
☐ Aunt Age at diagnosis _____ ☐ Mother's side ☐ Father's side
☐ Other family members Age at diagnosis _____ ☐ Mother's side ☐ Father's side

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Have you or a family member had cancer?

☐ No - or -

☐ Ovaries Age at diagnosis _____ Self _____ Family Member _____
☐ Other Age at diagnosis _____ Type _____