



ARYA STANA

BONE & BREAST CARE

MAMMOGRAPHY QUESTIONNAIRE

PATIENT TO COMPLETE

Date Referring Doctor

Title Name Surname

ID number: DOB Age

Email Address:

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 Pain Nipple discharge Trauma Other - please describe Right Left Right Left Right Left Right Left

Have you had any of the following?

No

- or -

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

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

Have you or a family member had cancer?

No

- or -

- Ovaries Other Age at diagnosis Self Family Member Type