EASTERN RADIOLOGISTS

Breast Imaging Center | 252.754.5227 | Mon–Fri 8am–5pm • Tues 8am–7pm
Kinston | 252.527.7077 | Mon–Fri 8am–5pm
Washington | 252.946.2137 | Mon–Fri 8am–5pm
252.752.5000 | easternrad.com

Patient Name _____ DOB ___ /___ /___ Date ___ /___ /___ MRN _____

QUESTIONNAIRE: MAMMOGRAM

Where was your last mammogram? _____ When? _____

Why are you having a mammogram today? ____ Routine Screening ____ Breast Problems Which breast? _____

Please explain the problem _____

_____

Do you have any other appointments today? _____ If yes, what? _____

PERSONAL RISK FACTORS

Check all that apply

_____ Diabetic
_____ Breast cancer gene Age ____
_____ History of breast cancer Age ____
Which breast? Left ___ Right ___
_____ Chemotherapy
_____ Radiation Therapy
_____ Mastectomy Left ___ Right ___
_____ Lumpectomy Left ___ Right ___
_____ History of other cancer
What type?_____ Age ____

In what country were you born? _____

Race: White____ Black____ Hispanic____ Other___

_____ Ashkenazi Jewish?

What is your highest level of education? _____

Height: _____ Weight: _____

GYNECOLOGICAL HISTORY (if applicable)

Age of first menstrual period_____
Number of live births _____
Age at first full term pregnancy_____
Date of last menstrual period _____
Menopause Age:_____
Left ovary removed Age: _____
Right ovary removed Age: _____
Hysterectomy Age:_____

FAMILY HISTORY OF CANCER

Blood Relative

Do you have a family history of breast cancer? YES NO
If yes, who? _____
Maternal or Paternal _____
Age at diagnosis? _____
Premenopausal_____ Postmenopausal _____

HORMONE HISTORY

	Currently Using	Age at First Use	Age at Last Use	Duration of Use
Hormonal Contraceptives	_____	_____	_____	_____
Estrogen	_____	_____	_____	_____
Progesterone	_____	_____	_____	_____
Tamoxifen	_____	_____	_____	_____
Raloxifene	_____	_____	_____	_____
Other	_____	_____	_____	_____

BREAST SURGERY HISTORY

Have you ever had a benign (noncancerous) breast biopsy? YES NO

If yes, which breast: _____ Date: _____

Any other breast surgery?

_____ Implants
_____ Breast reduction
_____ Other _____

Patient Signature _____ Technologists _____