Princeton Radiology
Excellence in Imaging

Diagnostic Mammography Questionnaire

Name:_____ D.O.B.___/___/___ Sex: M/F MRN:_____

DIAGNOSTIC MAMMOGRAM: PLEASE CHECK ANY THAT APPLY

☐ 6 month follow up
☐ Prior breast cancer within the last 3 years
☐ Felt something: *Description*: ☐ lump / ☐ focal pain
Side: ☐ right / ☐ left
Who felt it: ☐ I felt it / ☐ my doctor felt it --- *may check both*
For how long? _____

☐ Nipple discharge: *Side*: ☐ right / ☐ left / ☐ both sides
Color: ☐ clear / ☐ bloody / ☐ white, green, or yellow
For how long? _____

GENERAL HISTORY:

☐ YES NO ☐ Is there any chance you may be pregnant? Date of last menstrual period?_____
☐ YES NO ☐ Have you breast fed within the last 6 months?
☐ YES NO ☐ Are you taking any type of hormones? If yes, how long?_____
☐ YES NO ☐ Do you have breast implants? If yes, type: ☐ Silicone ☐ Saline
☐ YES NO ☐ Any prior imaging? Where/when? _____
☐ YES NO ☐ Prior surgery/biopsy? *Side*: ☐ right / ☐ left Result: ☐ benign ☐ malignant ☐ atypia
When? _____
☐ YES NO ☐ Prior breast cancer? *Side*: ☐ right / ☐ left / ☐ both sides Type: _____
*When?*_____
☐ YES NO ☐ Radiation treatments to your breast? ☐ R ☐ L *When?* _____
☐ YES NO ☐ Chemotherapy? *When?* _____
☐ YES NO ☐ Hormonal therapy? *When?* _____
☐ YES NO ☐ Do you smoke currently or have you ever smoked?
If YES, for how many years? _____ years
How many packs per day? _____ packs per day
How long ago did you quit? If still smoking, mark as "0": _____ years ago

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I acknowledge that all the information given is accurate and thereby consent to have a Mammography examination performed on me.

Signature:_____. Date:___/___/___

Technologist Notes: _____

_____

Technologist Initials: _____

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Breast Cancer Risk Questionnaire

Name:_________________________________ D.O.B.___/___/___ Age:_______

List relatives who have a history of breast or ovarian cancer & their age of onset below:

1° Relatives	**2° Relatives Mother's Side**	**2° Relatives Father's Side**
Parents, Siblings, Children	***Grandparents, Aunts, Nieces, Half-siblings***	***Grandparents, Aunts, Nieces, Half-siblings***
Age of Onset: ☐ Breast ________ ☐ Ovarian ________ (Relative)	Age of Onset: ☐ Breast ________ ☐ Ovarian ________ (Relative)	Age of Onset: ☐ Breast ________ ☐ Ovarian ________ (Relative)
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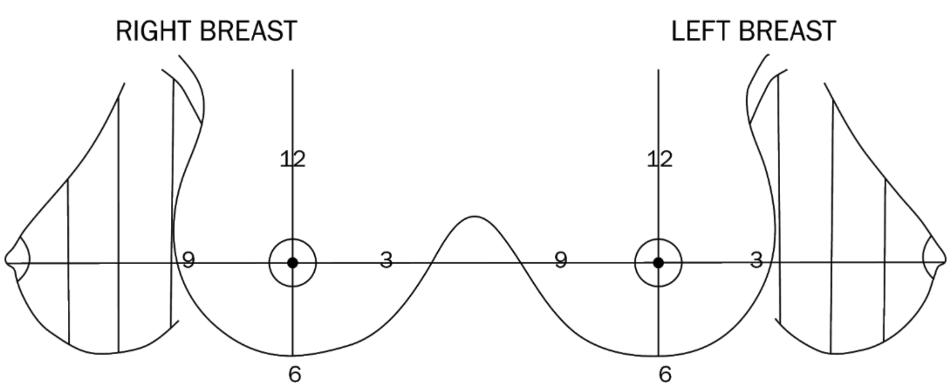
☐ YES NO ☐ Have you been tested for the BRCA gene? Result? ☐ Positive / ☐ Negative
☐ YES NO ☐ Does one of your 1° Relatives have the BRCA gene? (if unknown, check no)
☐ YES NO ☐ Did you have radiation therapy to the chest between 10 and 30 years of age?
☐ YES NO ☐ Do you have a personal history of breast cancer? Age at diagnosis:______________
☐ YES NO ☐ Is your family history unknown? (for example, if you were adopted, check yes).

DO NOT WRITE BELOW THIS LINE --- FOR TECHNOLOGIST USE



☐ YES NO ☐ Clause Score > 20 Claus Score: _______ Prior Density: ______