MAMMOGRAPHY QUESTIONNAIRE

NOTE: If you have applied any deodorant or powder, please inform the technologist.

Name: ____ DOB: _______________ Age: __________

Referring MD: ______________________________Date: ____________ Ethnicity: _____________

Have you had a mammogram before? Yes_______________ No________________

Where and when: ____

Reason for today's exam (circle all that apply): Routine, lump, pain, discharge, follow up

Date of last Clinical breast exam (physical exam by MD) ____________ by whom______________

Is there any history of breast cancer in yourself or family? Yes___________ No____________

If so, Whom? ___________________________ At what age? ____________________

Are you pregnant? _______________ Have you breast fed in past 3 months? ______________

Have you had a child?__________________ Your age at first child's birth____________________

Your age at first menses___________________ Your age at menopause____________________

Do you take hormones such as Estrogen, Premarin, Provera, Birth Control, Synthroid, Tamoxifen? Yes_____ No_____ Which type? _____________________Duration? ____________

Have you gained or lost weight in the past year? ____________ How much? ______________lbs

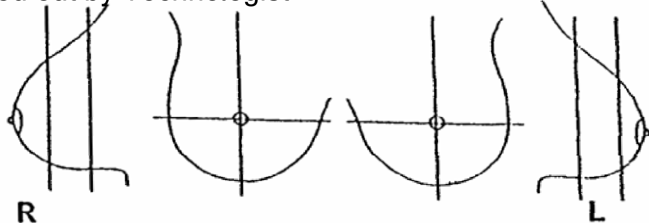
History of prior breast surgery, aspiration, biopsy, implants, reduction? Yes ____ No___

Describe_____________________ When___________ Where________________________

Any radiation to the chest before age 30 (Hodgkin's or non-Hodgkin's lymphoma)? Yes__ No__

==================== Below to be filled out by Technologist ==================

Nipples inverted? How long? __________
Breast size difference? _______________
o mole; Δ lump/mass; - - scar; ≈ pain



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Lifetime risk (Pt.) _____% Average_____% Technologist Initials _____

Call Back Authorization

It is sometimes necessary for a patient to be called back for additional imaging (extra mammo view/ultrasound). This does not necessarily mean a problem has been detected, but that additional images are necessary to complete the exam. If we cannot reach you by phone directly, do we have your permission to leave a message on your answering machine regarding the needed call back?

Yes__________________ No____________________

Phone number (home/cell etc)____
Under current HIPAA regulations, we are not allowed to leave a detailed message unless we have your permission.

Signature____________________________________ Date__________________

Medical Release Authorization

MD IMAGING
14 Raymond Avenue Poughkeepsie NY 12603
Tel: 845-471-2848 Fax: 845-471-2919

Medical Records Release:
To:_______________________________________
____
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I hereby authorize you to release to MD Imaging any information, including but not limited to, records, films, diagnosis and reports during the past ______ months/years.

__________________________________ ____________________
Signature Date

____
Print Name