Natchitoches Regional Medical Center
Radiology Department
Mammography Questionnaire

Technologist_____

Patient Name: _____Date:_____
D.O.B:_____Age:_____ Sex: ☐ Female ☐ Male
Address: _____
City: _____State:_____Zip:_____
Home Phone: _____Cell Phone: _____

Is this your first Mammogram? YES NO
When and where was your last Mammogram?_____
Do you have a family history of breast cancer? YES NO If yes, please explain_____
_____

Previous Treatment:	☐ NONE			When?
Cyst Aspiration	☐ Rt	☐ Lt	☐ Both	_____
Reduction Surgery	☐ Rt	☐ Lt	☐ Both	_____
Needle Biopsy	☐ Rt	☐ Lt	☐ Both	_____
Excisional Biopsy	☐ Rt	☐ Lt	☐ Both	_____
Lumpectomy	☐ Rt	☐ Lt	☐ Both	_____
Mastectomy	☐ Rt	☐ Lt	☐ Both	_____
Radiation Therapy	☐ Rt	☐ Lt	☐ Both	_____
Chemotherapy	☐ Rt	☐ Lt	☐ Both	_____

Medications: ☐ NONE How Long?
☐ Estrogen _____
☐ Progesterone _____
☐ Birth Control _____
☐ Tamoxifen _____

☐ Other (Please List)_____
_____

History:
Age when menstruation began_____
Age when menstruation stopped_____
Date of last menstrual period_____
Have you had your ovaries removed? ☐ YES ☐ NO
Have you had a hysterectomy? ☐ YES ☐ NO
Do you have any children? ☐ YES ☐ NO
If yes, How many? _____

Did you breastfeed? ☐ YES ☐ NO

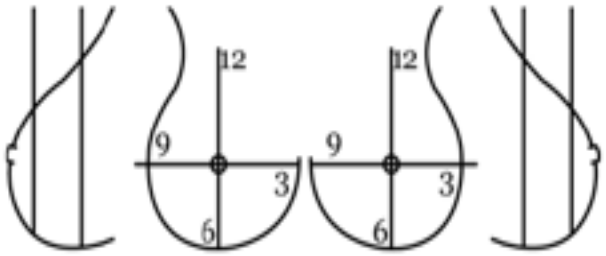
Do you have implants? ☐ YES ☐ NO
If yes, please check type:
☐ Silicone Gel ☐ Saline ☐ Combination
☐ Pre-pectoral (in front of muscle)
☐ Retro-pectoral (behind muscle)
☐ Augmentation Mammoplasty
☐ Other ☐ Unknown

MAMMO WKS

Are you having any problems with your breast? ☐ YES ☐ NO

If yes, check all that do apply:

				How Long?
Discomfort	☐ Rt	☐ Lt	☐ Both	_____
Mass	☐ Rt	☐ Lt	☐ Both	_____
Soreness	☐ Rt	☐ Lt	☐ Both	_____
Tenderness	☐ Rt	☐ Lt	☐ Both	_____
				Color?
Nipple Discharge	☐ Rt	☐ Lt	☐ Both	_____



MAMMO WKS