Mammography Questionnaire

Summit Health

MRN# DOB:

Patient Name: Date:

Provider:

Patient Name: _____ Ordering Provider**:** _____

Reason for today's exam:

☐ Baseline (no prior Mammogram) ☐ Routine Yearly Exam ☐ Short Term Follow-Up ☐ Problem-Related

Date of Last Mammogram: _____ Location: _____

Have you had a prior Breast Ultrasound? ☐ YES ☐ NO **Have you had a prior Breast MRI?** ☐ YES ☐ NO

Current Symptom: ☐ YES ☐ NO

Lump RT ☐ LT ☐

Pain RT ☐ LT ☐

Discovered by Self ☐ Doctor ☐

Nipple Discharge RT ☐ LT ☐

Other (Please Explain) RT ☐ LT ☐

Personal Medical History:

Are you possibly pregnant? ☐ YES ☐ NO

Date of last menstrual cycle: _____ Date of last physical breast exam: _____

In the last 6 months, have you taken: ☐ Hormones ☐ Birth Control Pills

In the last 6 months, have you: ☐ Breast Fed ☐ Lost weight

Have you been diagnosed with any of the following?

☐ Breast Cancer ☐ Ovarian Cancer ☐ Atypical Hyperplasia ☐ LCIS ☐ Other: _____

Family Medical History:

Has anyone in your family been diagnosed with Breast Cancer? ☐ YES ☐ NO

If Yes, specify whom and give age of diagnosis (include maternal and paternal):

Mother ☐_____Sister ☐_____Grandmother ☐_____Father ☐_____Aunt ☐_____Cousin ☐ _____Daughter ☐ _____

Has anyone in your family been diagnosed with Ovarian Cancer? ☐ YES ☐ NO

Surgical History: Previous Breast Procedures ☐ YES ☐ NO

Cyst Aspiration	RT ☐ LT ☐	Date: _____	Benign ☐	Malignant ☐	
Needle (Core) Biopsy	RT ☐ LT ☐	Date: _____	Benign ☐	Malignant ☐	
Biopsy in Radiology Suite	RT ☐ LT ☐	Date: _____	Benign ☐	Malignant ☐	
Biopsy in Operating Room	RT ☐ LT ☐	Date: _____	Benign ☐	Malignant ☐	
Breast Reduction or Lift	RT ☐ LT ☐	Date: _____	Benign ☐	Malignant ☐	
Implants	RT ☐ LT ☐	Date: _____	Saline ☐	Silicone ☐	
Malignant Lumpectomy	RT ☐ LT ☐	Date: _____	Radiation ☐	Chemotherapy ☐	
Mastectomy	RT ☐ LT ☐	Date: _____	Radiation ☐	Chemotherapy ☐	

Form # 820 Created 5/2020

Mammography Questionnaire

Summit Health

MRN# DOB:

Patient Name: Date:

Provider:

I have personally completed the above questionnaire. Should the results of my mammogram require any type of surgical follow-up, I authorize *Summit Medical Group* to obtain pathology results from my doctor, hospital and/or surgeon in accordance with FDA under MQSA guidelines.

_____ _____

Patient Signature (or person authorized to sign for Patient) Date

_____

Relationship to Patient if signing for Patient

_____ _____

Interpreter Signature (or ID# if using service), as applicable Date