

**SUMMIT
MEDICAL
GROUP**

Mammography Questionnaire

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

Discovered by Self Doctor

Lump RT LT

Nipple Discharge RT LT

Pain 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

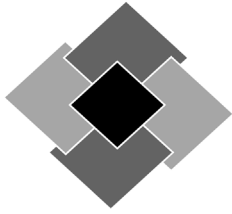
If Yes, specify whom and give age of diagnosis (include maternal and paternal):

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 <input type="checkbox"/>	LT <input type="checkbox"/>	Date: _____	Benign <input type="checkbox"/>	Malignant <input type="checkbox"/>
Needle (Core) Biopsy	RT <input type="checkbox"/>	LT <input type="checkbox"/>	Date: _____	Benign <input type="checkbox"/>	Malignant <input type="checkbox"/>
Biopsy in Radiology Suite	RT <input type="checkbox"/>	LT <input type="checkbox"/>	Date: _____	Benign <input type="checkbox"/>	Malignant <input type="checkbox"/>
Biopsy in Operating Room	RT <input type="checkbox"/>	LT <input type="checkbox"/>	Date: _____	Benign <input type="checkbox"/>	Malignant <input type="checkbox"/>
Breast Reduction or Lift	RT <input type="checkbox"/>	LT <input type="checkbox"/>	Date: _____	Benign <input type="checkbox"/>	Malignant <input type="checkbox"/>
Implants	RT <input type="checkbox"/>	LT <input type="checkbox"/>	Date: _____	Saline <input type="checkbox"/>	Silicone <input type="checkbox"/>
Malignant Lumpectomy	RT <input type="checkbox"/>	LT <input type="checkbox"/>	Date: _____	Radiation <input type="checkbox"/>	Chemotherapy <input type="checkbox"/>
Mastectomy	RT <input type="checkbox"/>	LT <input type="checkbox"/>	Date: _____	Radiation <input type="checkbox"/>	Chemotherapy <input type="checkbox"/>



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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