North Bay Regional Health Centre

Diagnostic Imaging
Mammography Questionnaire

Pertinent Patient History

Have you ever had a previous mammogram? ☐ **Yes** ☐ **No**
If yes, please indicate when: Month: ____________ Year: ___________ ☐ Uncertain
Where: ____

Have you or anyone in your immediate family ever had breast cancer? ☐ **Yes** ☐ **No** ☐ **Uncertain**

☐ Myself Year: _________ ☐ Mother _____ (Age) ☐ Sister ______ (Age) ☐ Daughter ______ (Age)
☐ Grandmother ☐ Aunt ☐ Cousin (☐ Maternal ☐ Paternal)

Have you had previous breast surgeries or treatments? ☐ **Yes** ☐ **No** ☐ **Uncertain**

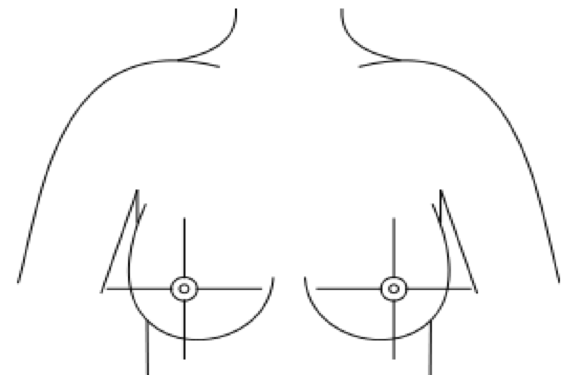
☐ Cyst aspiration ☐ R ☐ L When: _________ ☐ Mastectomy/Lumpectomy ☐ R ☐ L When: _________
☐ Core needle Bx ☐ R ☐ L When: _________ ☐ Nodes Removed ☐ Positive ☐ Negative
☐ Surgical Bx ☐ R ☐ L When: _________ ☐ Radiation ☐ Chemotherapy

☐ Reduction/Lifts/Reconstructive ☐ R ☐ L When: ____________
☐ Implants ☐ R ☐ L When: ____________
☐ Trauma ☐ Sebaceous Cysts ☐ Mastitis/Infection ☐ R ☐ L When: ____________

Has your period stopped for more than 12 months?
☐ No ☐ Yes (naturally) ☐ Yes (surgically) _____________ ☐ Yes (other, please specify) ________________
Are you on any hormone replacement? ☐ Yes ☐ No ____________________________________

Why are you having this mammogram?

☐ Screening/Yearly Routine
☐ 3 to 6 month follow up ☐ R ☐ L
☐ Lump or thickening ☐ R ☐ L
☐ Skin changes/retraction ☐ R ☐ L
☐ Breast implant problems ☐ R ☐ L
☐ Pain/Tenderness (chronic or acute) ☐ R ☐ L
☐ Nipple discharge (color of discharge __________) ☐ R ☐ L
☐ Other (please specify) _____________________________



Has there been any changes since you saw your doctor? ☐ **Yes** ☐ **No**

Comments: ____
____

Technologist Print Name: ____________________ Technologist signature: ______________________________