Mammogram/Breast Ultrasound Questionnaire
Please complete/update for accurate lifetime breast cancer risk percentages

Name: ______________________________ DOB: __________ Age: ____ Weight: ______ Height: ___' ___"

Prior Mammograms: Y or N Facility: ______________________________ Date: __________

Prior Breast Ultrasound: Y or N Facility: ______________________________ Date: __________

Prior Breast MRI: Y or N Facility: ______________________________ Date: __________

Age at 1st period: ___ Number of biological children: ___ Age at 1st pregnancy: ___ Ashkenazi Jewish decent? Y or N

Are you pregnant? Y or N If yes, are you breast feeding? Y or N Race: __________ Ethnicity: __________

Have you reached menopause? Y or N If yes, what age: ______

Hysterectomy Y or N If yes, what age: _________ Ovaries removed? Y or N If yes, Right, Left or Both

Hormone Replacement: Y or N If yes, how long _________ Type: ______________________________

Breast Surgery History: (Please circle and fill out any that you have had)

Breast Implants: Right, Left or Both Date: __________ Type: Silicone Gel, Saline, Combination, Unknown

Breast Reduction: Right, Left or Both Date: __________

Cyst Aspiration: Right, Left or Both Date: __________

Needle Biopsy: Right, Left or Both Date: __________ Results if known: __________________

Surgical Biopsy: Right, Left or Both Date: __________ Results if known: __________________

Personal Breast Cancer History: (Circle and fill out if applicable)

Do you have a personal history of breast cancer? Y or N Right, Left or Both Breasts

Type of Cancer: ______________________________ Date of Diagnosis: __________________

Has your Breast Cancer Treatment Ended? Y or N Date of Last Treatment: __________________

Mastectomy: Right, Left or Both Date: __________

Lumpectomy: (Cancer) Right, Left or Both Date: __________

Chemotherapy: Right, Left or Both Date: __________

Radiation Right, Left or Both Date Started: __________ Date Ended: __________

Tamoxifen or Nolvadex Y or N Date Started: __________ Date Ended: __________

Family History of Breast or Ovarian Cancer:

Breast Cancer (relationship and age at diagnosis) Ovarian Cancer (relationship and age at diagnosis)

______________________________ ______________________________

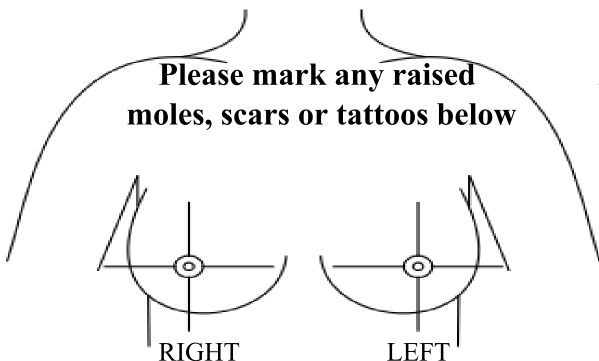
______________________________ ______________________________

Genetic Testing: Yes or No Circle all that apply: Self or Family Members

Genetic Testing Results: Please circle all applicable: Negative BRCA1 BRCA2

Reason for having this mammogram? Screening or Problem

If problem, please explain: ______________________________



Physician at Stark Women's Center: ______________________________

Other Physician requesting report: ______________________________

Address: ______________________________

______________________________ Phone: __________________

Appointment Date: ______________ **Time:** ______________

PLEASE bring this form to your appointment…..if you are more than fifteen minutes late, your appointment will be rescheduled.