SCHAFFER, SCHONHOLZ & DROSSMAN, LLP

MAMMOGRAPHY/BREAST SONOGRAPHY QUESTIONNAIRE (FEMALE PATIENTS)

KINDLY COMPLETE QUESTIONS 1-13 **PLEASE PRINT CLEARLY** DATE: _____

1. Name: _____
Last First MI

2. Age: _____ 3. Date of Birth: _____ 4. First day of last menstrual period: _____

5. Have any of your blood relatives, maternal and/or paternal, ever had breast cancer? Yes _____ No _____

If yes, what relationship and at what age? _____

6. Gene mutation status: (BRCA1, 2, CHEK2, or other) Yes (specify) _____ No ____ Unknown/never tested _____

7. Is this your first mammogram? . . . . . Yes _____ No _____

If your last mammogram was performed at a different facility: When _____

Where: _____ Did you bring the corresponding images and records? Yes ____ No ____

8. Have you ever had breast surgery? . . . . . Yes _____ No _____

Type (Please circle) Aspiration, Biopsy, Reduction, Implants, Lumpectomy, Mastectomy, Radiation Therapy

When: _____ Diagnosis: _____

9. Age at birth of first child: _____

10 . Are you experiencing any problems with your breasts now? . . . . . Yes _____ No _____

If yes: Lump _____ Which side _____

Discharge _____ Which side _____

Pain/Tenderness _____ Which side _____

11. Have you had a manual/physical breast exam performed by a physician in the last year? . . . . . Yes _____ No _____ When: _____

12. Are you taking any hormones or oral contraceptives at this time? . . . . . Yes _____ No _____

If yes, please state type: _____ For how long: _____

13. Name of your referring physician: _____

Patient acknowledges above information is correct. Patient's signature: _____

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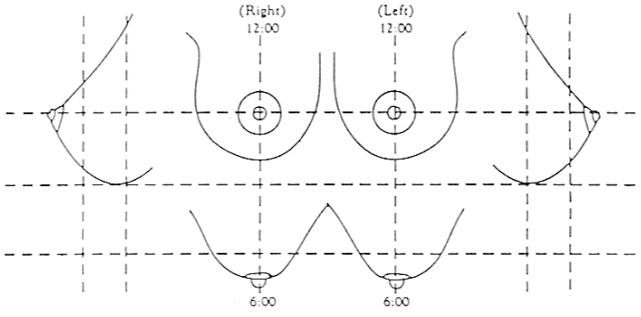
Technologist: Please indicate breast changes on diagram, e.g. lumps, scars, skin changes, moles, nipple retraction, etc.

COMMENTS: _____

Radiologist's Name: _____, MD Technologist's Name: _____



Examination Room

(please circle one)

7 8

DRESSING ROOM: _____