

MAMMOGRAPHY/BREAST SONOGRAPHY QUESTIONNAIRE (MALE PATIENTS)

KINDLY COMPLETE QUESTIONS 1-11

PLEASE PRINT CLEARLY

DATE: _____

1. Name: _____
Last First MI

2. Age: _____ 3. Date of Birth: _____

4. Have any of your blood relatives, maternal and/or paternal, ever had breast cancer?Yes _____ No _____
If yes, what relationship and at what age? _____

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

6. 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 _____

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

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

When: _____ Diagnosis: _____

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

If yes: Lump _____ Which side _____

Discharge _____ Which side _____

Pain/Tenderness _____ Which side _____

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

10. Are you taking any hormones at this time? Yes _____ No _____

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

11. Name of your referring physician: _____

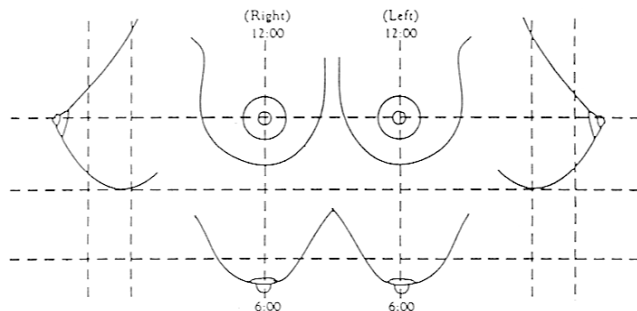
Patient acknowledges above information is correct. Patient's signature: _____

..... **FOR OFFICE USE ONLY** **DO NOT WRITE BELOW THIS LINE**

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: _____