SCHONHOLZ and DROSSMAN, LLP

MAMMOGRAPHY/BREAST SONOGRAPHY QUESTIONNAIRE

KINDLY COMPLETE QUESTIONS 1-12 **PLEASE PRINT CLEARLY** DATE: ______________________

1. Name: ____
   Last First MI

2. Age: ______ 3. Date of Birth: _______________ 4. If applicable, first day of last menstrual period: _______________

5. **PLEASE CIRCLE WHICH FAMILY MEMBER (IF APPLICABLE)**
   Has your mother, sister, daughter, grandmother, maternal aunt and paternal aunt had cancer of the breast?
   Yes ________ at what age? _________ No _________ **BRCA STATUS:** _________________________

6. Is this your first mammogram . . . . Yes ________ No _________

   6b. 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. Age at birth of first child: _______________________

9. Are you experiencing any problems with your breasts now? . . . . Yes ________ No __________

   If yes: Lump ____________________ Which side ____________________

   Discharge _________________ Which side ____________________

   Pain/Tenderness ____________ Which side ____________________

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

11. Are you taking any hormones or oral contraceptives at this time? . . . . Yes ________ No _________

If yes, please state type: ______________________________________ For how long: _____________________________

12. Name of your referring physician: ____

Patient acknowledges above information is correct PATIENT'S SIGNATURE: _________________________

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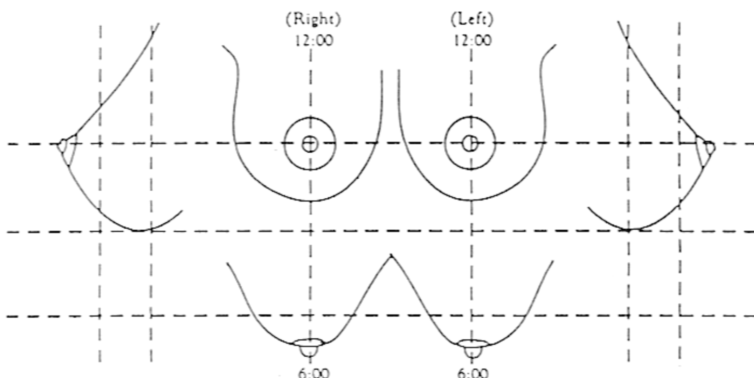
Technologist: Please indicate breast changes on diagram, e.g. lumps, scars, skin changes, moles, nipple retraction, etc.

COMMENTS: ____

Radiologist's Name: ________________________________, MD Technologist's Name: ____________________________



Examination Room

(please circle one)

7 **8**

DRESSING ROOM: ___________

Updated 12/16/21