Colorado Canyons
HOSPITAL & MEDICAL CENTER

Services provided by Family Health West

Mammography Questionnaire

Maiden Name: _____

What is the reason you are having breast imaging today?

- ☐ Routine screening
- ☐ I am here for a follow-up from a prior visit (3 mo., 6 mo.)
- ☐ I am here for a new breast problem *(pain, nipple discharge, lumps, retraction, etc.)*_____
  _____

Are you or could you be pregnant? ☐ Yes ☐ No

Is this your first mammogram? ☐ Yes ☐ No

If no, where and when did you have your last Mammogram? _____
_____
_____

Age of Menopause? _____

YOU EVER HAD ANY OF THE FOLLOWING?	YES	NO	RIGHT	LEFT	WHEN	BIOPSY RESULTS
Implants						
Cyst Aspiration						
Needle Biopsy						
Excisional Biopsy						
Stereo Biopsy						
Breast Reduction						
Lumpectomy						
Mastectomy						
Radiation Therapy						
Chemotherapy						

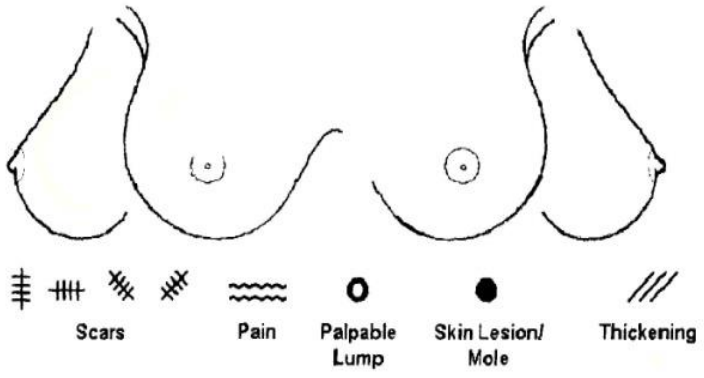
Do you have a family history of breast cancer? If yes, who?

Have you ever had breast cancer? What type? When? Which Breast?

Have you ever used contraceptives? What kind? When? How Long? (*Estrogen, Premarin, Provera, Tamoxifen, Arimedwx, Femara, Megace, Lupron)*

Technologist fill out only. Tech Initials _____

Tech Comments?



I the undersign give Family Health West Hospital permission to obtain my prior mammograms, reports, and permission to obtain my confidential record (follow-up, breast surgery, pathology and or consultation notes).

I acknowledge this information I have provided is accurate to the best of my knowledge.

Patient Signature: _____Date: _____