Mammogram Questionnaire

SSN: ______________________ DOB: ______________ Patient ID #: ______________

Last Name: ________________________ First Name: ______________ Middle Initial: ____

Address: ____

City: ____________________________ State: ______________ Zip: ______________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Ordering Provider: ______________________________ Date of Exam: ______________

Previous Mammogram? ☐ Yes ☐ No Where: ________________ When: ______________

***Are you presently having any of these symptoms?**

☐	Pain	☐ Right	☐ Left	☐ No Symptoms
☐	Nipple Discharge	☐ Right	☐ Left	☐ No Symptoms
☐	Lump	☐ Right	☐ Left	☐ No Symptoms
☐	Thickening	☐ Right	☐ Left	☐ No Symptoms

***Previous breast therapy / surgery:**

☐	None			
☐	Biopsy	☐ Left	☐ Right	When: ______________
☐	Aspiration	☐ Left	☐ Right	When: ______________
☐	Mastectomy	☐ Left	☐ Right	When: ______________
☐	Breast Augmentation	☐ Left	☐ Right	When: ______________
☐	Breast Reduction	☐ Left	☐ Right	When: ______________

***History of Cancer:**

Is there a history of breast cancer? ☐ Yes ☐ No
If yes, who? ____

I authorize The Woman's Clinic in Clarksdale, Mississippi to secure any previous films from:

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______________________________ ☐ Permanent Transfer
PATIENT SIGNATURE