Princeton Radiology
Excellence in Imaging

Diagnostic Mammography Questionnaire

Name:_____ D.O.B.___/___/___ Sex: M/F MRN:_____

☐ ***YES NO*** ☐ ***Have you received a COVID vaccine? If yes, please answer the following: Pfizer/Moderna/J&J***
1st dose date: _____ ***Arm: RIGHT / LEFT 2nd dose date:*** _____ ***Arm: RIGHT / LEFT***

DIAGNOSTIC MAMMOGRAM: PLEASE CHECK ANY THAT APPLY

☐ 6 month follow up
☐ Prior breast cancer within the last 3 years
☐ Felt something: *Description*: ☐ lump / ☐ focal pain
Side: ☐ right / ☐ left
Who felt it: ☐ I felt it / ☐ my doctor felt it --- *may check both*
For how long? _____

☐ Nipple discharge: *Side*: ☐ right / ☐ left / ☐ both sides
Color: ☐ clear / ☐ bloody / ☐ white, green, or yellow
For how long? _____

GENERAL HISTORY:

☐ YES NO ☐ Is there any chance you may be pregnant? Date of last menstrual period?_____
☐ YES NO ☐ Have you breast fed within the last 6 months?
☐ YES NO ☐ Are you taking any type of hormones? If yes, how long?_____
☐ YES NO ☐ Do you have breast implants? If yes, type: ☐ Silicone ☐ Saline
☐ YES NO ☐ Any prior imaging? Where/when? _____
☐ YES NO ☐ Prior surgery/biopsy? *Side*: ☐ right / ☐ left Result: ☐ benign ☐ malignant ☐ atypia
When? _____
☐ YES NO ☐ Prior breast cancer? *Side*: ☐ right / ☐ left / ☐ both sides Type: _____
*When?*_____
☐ YES NO ☐ Radiation treatments to your breast? ☐ R ☐ L *When?* _____
☐ YES NO ☐ Chemotherapy? *When?* _____
☐ YES NO ☐ Hormonal therapy? *When?* _____
☐ YES NO ☐ Do you smoke currently or have you ever smoked?
If YES, for how many years? _____ years
How many packs per day? _____ packs per day
How long ago did you quit? If still smoking, mark as "0": _____ years ago

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I acknowledge that all the information given is accurate and thereby consent to have a Mammography examination performed on me.

Signature:_____. Date:___/___/___

Technologist Notes: _____

_____

Technologist Initials: _____