Princeton Radiology
Excellence in Imaging

Screening 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***

SCREENING MAMMOGRAM:

☐ I have no breast related symptoms or complaints

☐ I have a specific concern _____

Please note, if you have a specific concern such as a lump or focal and non-cyclical pain, you may need to obtain a referral for a diagnostic mammogram and reschedule your exam.

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 or biopsy:

Side: ☐ right / ☐ left / ☐ both sides

Result: ☐ benign ☐ malignant ☐ atypia_____

*When:*_____

☐ YES NO ☐ Do you have a personal history of breast cancer?

Side: ☐ right / ☐ left / ☐ both sides

Type: _____

Age: _____

☐ 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: _____

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Name:_________________________________ D.O.B.___/___/___ Age:_______

List relatives who have a history of breast or ovarian cancer & their age of onset below:

1° Relatives	2° Relatives Mother's Side	2° Relatives Father's Side
Parents, Siblings, Children	***Grandparents, Aunts/Uncles, Nieces, Half-siblings***	***Grandparents, Aunts/Uncles, Nieces, Half-siblings***
Age of Onset: ☐ Breast _______ ☐ Ovarian _______ (Relative)	Age of Onset: ☐ Breast _______ ☐ Ovarian _______ (Relative)	Age of Onset: ☐ Breast _______ ☐ Ovarian _______ (Relative)
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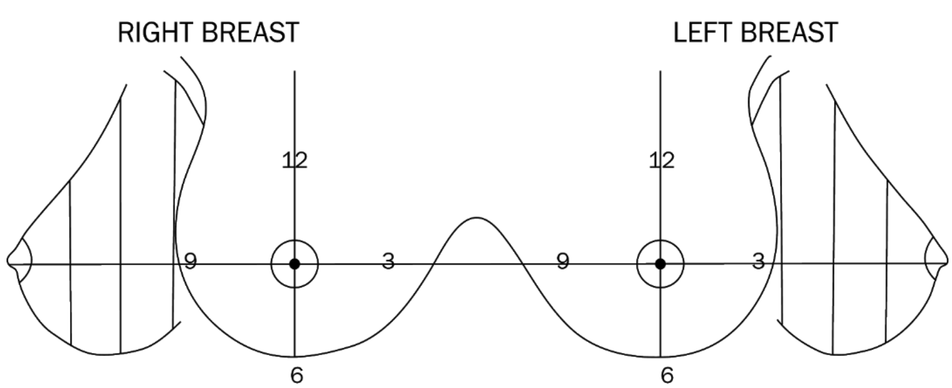
☐ YES NO ☐ Have you been tested for the BRCA gene? Result? ☐ Positive / ☐ Negative
☐ YES NO ☐ Does one of your 1° Relatives have the BRCA gene? (if unknown, check no)
☐ YES NO ☐ Did you have radiation therapy to the chest between 10 and 30 years of age?
☐ YES NO ☐ Do you have a personal history of breast cancer? Age at diagnosis:____________
☐ YES NO ☐ Is your family history unknown? (for example, if you were adopted, check yes).

DO NOT WRITE BELOW THIS LINE --- FOR TECHNOLOGIST USE



☐ YES NO ☐ Claus Score > 20 Claus Score _______ Prior Breast Density: ______