



BAPTIST M&S IMAGING

BREAST QUESTIONNAIRE

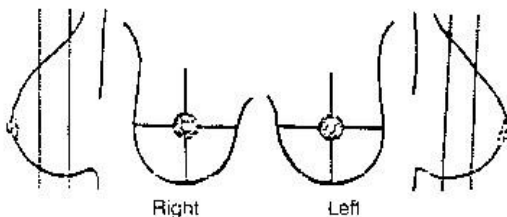
Patient Name: _____ DOB: _____

Referring Physician: _____ Date of next physician visit: _____

Last 4 numbers of SS#: _____

YES NO

- 1. Are you pregnant?
- 2. Do you have a family history of breast cancer? Age at Diagnosis: _____
(Mother, Sister, Grandmother, Aunt, or Daughter)
- 3. Do you have a personal history of breast Cancer? Age at Diagnosis: _____
- 4. Have you had a mammogram before?
If yes, where: _____ Approximate date: _____
- 5. Are you or your doctor feeling any lumps in your breasts now?
If yes, please diagram the location on the drawing.



- 6. Are you having any of the following symptoms?

Left	Right	
<input type="checkbox"/>	<input type="checkbox"/>	Palpable lump or thickening
<input type="checkbox"/>	<input type="checkbox"/>	Bloody discharge
<input type="checkbox"/>	<input type="checkbox"/>	Non-bloody discharge
<input type="checkbox"/>	<input type="checkbox"/>	Skin thickening or dimpling
<input type="checkbox"/>	<input type="checkbox"/>	Nipple abnormality
<input type="checkbox"/>	<input type="checkbox"/>	Pain
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

Left	Right	Date
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____

- 8. Are you currently taking Hormones? (birth control pills, Estrogen, or Progestin)
If yes, which ones? _____ Number of years? _____

Patient Signature: _____ Date: _____

Baptist M&S Staff FULL Signature: _____ Date: _____