MAMMOGRAM QUESTIONNAIRE

1. Do you have a history of Breast Cancer? •! No ❑ Yes

2. Does anyone in your family have a history of breast cancer? Cl No ❑ Yes

3. Do you have breast implants? ❑ **No** ☐ Yes

4. Do you have lumps or nodules in or around breast area/under arms? Cl No ❑ Yes If yes, where? ____________________

5. Do you have any nipple discharge? Cl No El Yes If yes, which nipple? ☐ Left ☐ Right

6. Do you have inverted nipples? [Are nipples turn inward] Cl No ☐ Yes

7. Are you wheelchair? ❑ No ☐ Yes Any difficulty standing? ☐ No Cl Yes

8. Have you had a previous mammogram(s)? Cl No El Yes If yes, where?

   Are you able to gate a copy of the films? ❑ No ❑ Yes

____________________ ____________________
Client Signature Date

CLIENT LAST NAME: **FIRST NAME:** **HCH#:**