NORTH COAST Radiology

Form For

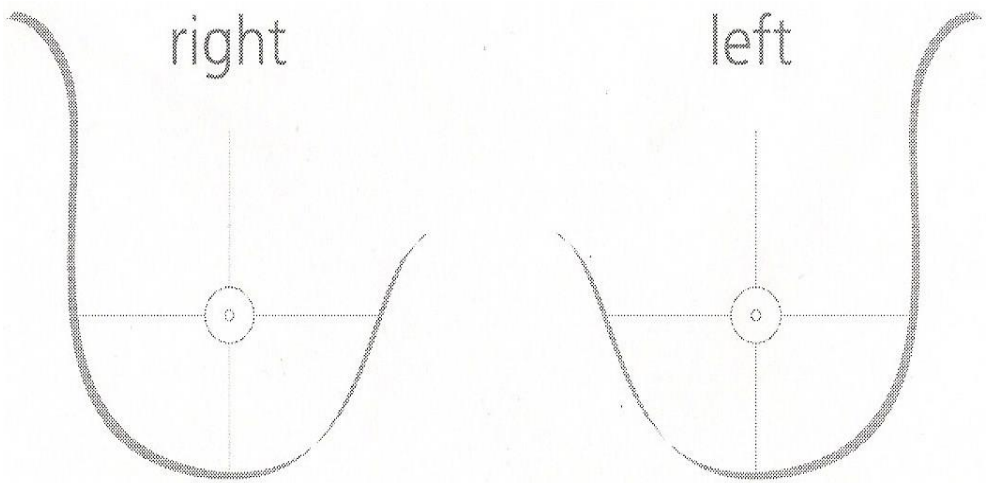
Mammography Patient Questionnaire

Name _____ Age _____ DOB _____

Are you pregnant?	☐ No	☐ Yes	
Have you had children? If so, how many?	☐ No	☐ Yes	_____
At present, do you have any lumps in your breasts?	☐ No	☐ Yes	_____
At present, do you have any discomfort, pain or soreness in your breasts?	☐ No	☐ Yes	_____
Do you have any nipple discharge? If so, what colour is it?	☐ No	☐ Yes	_____
Have you had any breast surgery?	☐ No	☐ Yes	_____
Have you had breast cancer?	☐ No	☐ Yes	_____
Is there a family history of breast cancer?	☐ No	☐ Yes	_____
Are you are on hormone replacement therapy (HRT)? If so, for how long?	☐ No	☐ Yes	_____
Do you have breast implants?	☐ No	☐ Yes	
Have you had a mammogram previously? If so, where?	☐ No	☐ Yes	_____

Patient Signature _____

To be completed by Mammographer



☐ Sonographer to review images with Radiologist