CLARKE

CENTRE D'IMAGERIE MÉDICALE

MEDICAL IMAGING CENTER

Mammogram Questionnaire

Name: _____ **Pregnant?** _____

*Patient Section

Have you ever had a mammography? Yes ☐ No ☐

At Clarke: Yes ☐ No ☐

If not, Where: _____

In what year? _____

Has anyone in your family ever had breast cancer?

Grandmother: at _____ years old

Mother: at _____ years old

Aunt: at _____ years old

Sister: at _____ years old

Daughter: at _____ years old

Father: at _____ years old

Have you had radiotherapy treatments?

Yes ☐ No ☐ Duration: _____

Have you had chemotherapy treatments?

Yes ☐ No ☐ Duration: _____

(Patient under 45 years old)

Are you breast feeding?

Yes ☐ No ☐

Did you breast feed in the last 6 months?

When did you stop breast feeding?

Date: _____

Are you or did you take any hormones for menopause?

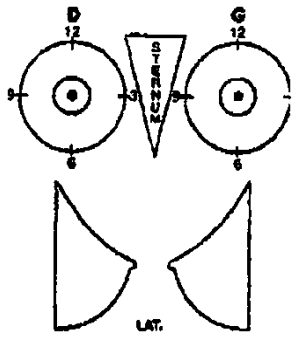
Yes ☐ No ☐

If yes, How long? _____

**Technologist section

Drainage	_____	Right ☐	Left ☐
Cyst	_____	Right ☐	Left ☐
Biopsy	_____	Right ☐	Left ☐
Mastectomy	_____	Right ☐	Left ☐
Reduction	_____	Right ☐	Left ☐
Implants	_____	Right ☐	Left ☐
Benign Surgery	_____	Right ☐	Left ☐
Lumpectomy	_____	Right ☐	Left ☐
Reconstruction	_____	Right ☐	Left ☐

Have you noticed?			**Since When?**
Lump	Right ☐	Left ☐	_____
Pain or Sensitivity	Right ☐	Left ☐	_____
Discharge	Right ☐	Left ☐	_____
Nipple retraction	Right ☐	Left ☐	_____



Further comments: _____

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Patients Signature **Technologist's Signature** **Date**

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