Aria
Jefferson Health

HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

Mammography Questionnaire

Please read and answer all questions

Name:______________________________ Date of Birth:____-____-____

Have you ever had a mammogram before? YES__________ NO__________

If yes: When______________________ Where:______________________________

1- Why are you having this mammogram? Routine________ Breast problem________

2- Do you have any of the following:

	YES	NO	Right breast	Left breast
New lump or mass				
Pain and tenderness				
Change in skin or nipple				
Nipple discharge				

3- Have you ever had BREAST cancer? YES______ NO______ Right breast______ Left Breast______
What Year? __________ Chemotherapy: YES______NO______ Radiation: YES______NO______

4- Have you ever had any of the following breast operations?

	YES	NO	Right breast	Left breast	When	Where
Biopsy						
Mastectomy						
Lumpectomy						
Implants						
Cyst Aspiration						
Breast reduction						

5- Was your first pregnancy after age 30? YES__________ NO__________

6- When was your last period?______________________________

7- Any chance of pregnancy? YES__________ NO__________

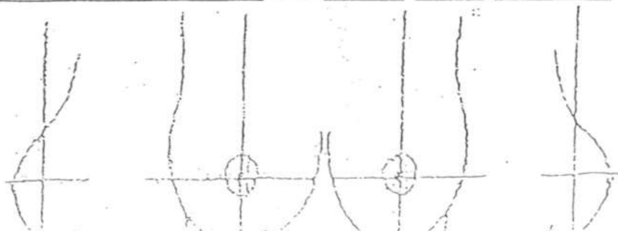
8- Are you currently taking hormones or birth control? YES__________ NO__________
If yes, which type:__________________ How long have you been on them?__________

9- Have any close family member had breast cancer? YES__________ NO__________
If yes: Who: __________ __________ at what age__________

10- Have you ever had any OTHER type of cancer? Type__________________ Age__________

Patient Signature X______________________________ Date____-____-____

Technologist Signature______________________________



Aria Jefferson Health
HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

HIGH RISK BREAST CANCER QUESTIONNAIRE

NAME:_______________________________ Date of Birth______________ AGE:________

Phone number:_________________________

Your personal and family history of cancer is important. **Please answer the following questions about you and your family, including who had the following cancers and their age at diagnosis:**

	YOU - AGE	SIBLINGS/ CHILDREN AGE	MOTHER'S SIDE - AGE	FATHER'S SIDE - AGE
Examples	*none*	*sister 47*	*grandmother 62* *cousin 36*	*aunt 59*
BREAST CANCER				
OVARIAN CANCER				
UTERINE CANCER (ENDOMETRIAL)				
COLON/RECTAL CANCER				
MELANOMA				
PANCREATIC CANCER				
PROSTATE CANCER				

Are you of Ashkenazi Jewish descent? ____yes____no

Have you or any family members ever been tested for hereditary risk of cancer? ___yes ___no
If yes, what are the results of the genetic test:________________

PATIENT SIGNATURE:____ Date:________________

For Office Use Only: **Patient is at high risk?** ☐ **YES** ☐ **NO**

Torresdale Radiology Department

NAME: ______________________ ARRIVAL TIME: ________________

(please print)

WHAT SERVICE ARE YOU HERE FOR: (please check)

Ultrasound _______ Mammography _______

Please circle your response to the following questions:

1. Have you fallen in the past year? Yes

   No

2. Do you feel unsteady when standing/walking or need assistance? Yes

   No

3. Do you worry about falling? Yes

   No

FOR OFFICE USE ONLY:

Was Fall Education Provided Yes No Refused

Initials: __________ Date: ____________ Time Rec'd:__________Time Completed:__________

(Cut here)--