



1800 W. Hibiscus Blvd., Suite 100 – Melbourne, FL 32901 - (321) 726-3800 – Fax (321) 726-3842

Mammography Questionnaire

NAME: _____ DOB: _____ DATE: _____

- Have you ever had a mammogram? Yes No Don't Know
- Are you on hormone replacement therapy? Yes No Don't Know
- Have you had a breast reduction? Yes No Don't Know
- Do you have breast implants? Yes No Saline Silicone
- Have you ever had a breast biopsy? Yes No Right Left
- Have you ever been diagnosed with breast cancer? Yes No Right Left
- Have you ever had a mastectomy Yes No Right Left
- Do you have a family history of breast cancer? Yes No
- Mother Sister Aunt Daughter Grandmother

If your last mammogram **WAS NOT** done here at University Center Imaging **OR** you did not bring your films with you today, please sign below.

Has your last name changed since your last mammogram? Yes No
If yes, what was your previous last name? _____

Previous facility name and address: _____

Phone Number: _____ Fax Number: _____

I hereby authorize the release of mammography films and breast related medical records.

Please mail to: **University Center Imaging**
1800 West Hibiscus Blvd., Suite 100
Melbourne, FL 32901

Your signature _____

****IF YOU ARE BETWEEN THE AGES OF 12-55, PLEASE
FILL OUT THE BACK OF THIS FORM****



PREGNANCY INFORMATION

Recognizing that there is a very small, but unknown risk to a developing fetus exposed to diagnostic levels of radiation, it is imperative that every effort is made to avoid unnecessary exposure to the fetus. For this reason, we require all females ages 12 to 55 to answer the following questions before proceeding with your x-ray examination.

Patient's Name: _____

Females 12-55 years of age, please answer the following questions:

I understand that radiation can be harmful to the unborn child.

Date of last menstrual period: _____.

Please complete the following:

- I am pregnant.
- I may be pregnant.
- I am not pregnant.

Comments:

Patient Signature

Date

Parent or Guardian, if under 18

Date

DIAGNOSTIC MAMMOGRAM

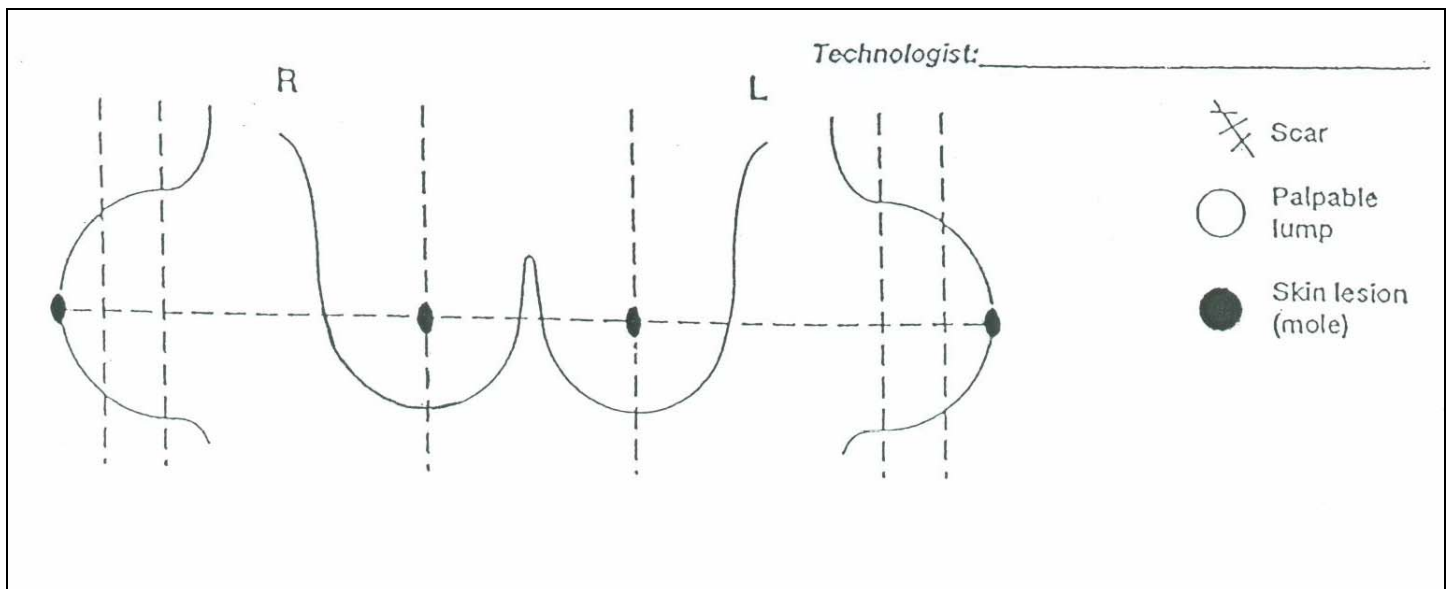
Please place patient label here

Short Term Follow Up	Yes	No	Right	Left
	Calcifications	Density	Nodularity	

Palpable Breast Lump	Yes	No	Right	Left
	Felt by patient	Felt only by Physician		

Breast Discharge Color	Yes	No	Right	Left
	Color _____			

Focal Breast Tenderness	Yes	No	Right	Left
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