DOCTORS RADIOLOGY CENTER

PEACH PLAZA
1500 St. Georges Ave.,
Avenel, N.J. 07001

MAMMOGRAPHY PATIENT QUESTIONNAIRE

Name__________________________ SS#___ - ___ - _____ Date______________
Age_________ Age during first pregnancy_________ Number of pregnancies__________
Age at onset of menstruation _________ Date of last menstrual period__________
If you have had any of the following procedures on your breasts, please indicate the year:

LEFT (dates)		RIGHT (dates)
______________	Cyst Aspiration	______________
______________	Biopsy	______________
______________	Lumpectomy	______________
______________	Radiation Therapy	______________
______________	Mastectomy	______________

Have you ever taken hormones? No___ Yes___ (when?)______________

Have you had a hysterectomy? No___ Yes___ (when?)______________

Were your ovaries removed? No___ Yes___ (when?)______________

Have you had breast implants? No___ Yes___ (when?)______________

Do you perform a self examination of your breasts? No___ Yes___ (how often?)__________
When was your last visit to the doctor for examination of your breasts?______________

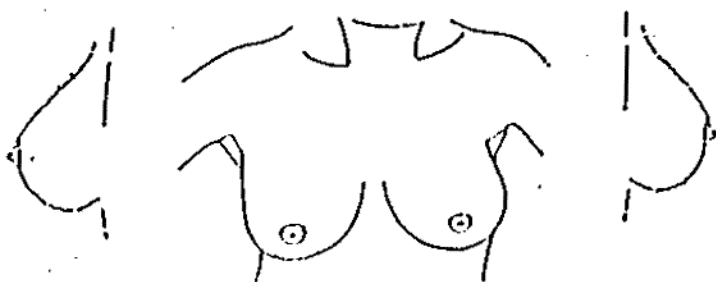
Have any of your close relatives had cancer of the breast?
Grandmother___ Mother___ Aunt___ Sister___ Daughter___ Other______________

Do you currently have any problems or complaints? No________ Yes ______________
(what?)____

Have you had a previous mammogram? No___ Yes___ (when?)______________
If yes, where was the most recent prior exam?
Here___ Rahway Hospital___ Other*______________________
*Note: It is important to submit this exam for comparison purposes.

Thank you for completing this form. The technologist will be with you as soon as possible.

Do not write below this line--- for office use only



Technologist ______________________