



MAMMOGRAPHY QUESTIONNAIRE

Date:

Kindly complete questions 1-10. (Please Print)

- 1. Name: (Last) (First) (M.I.)
2. Age: Date of birth:
3. Telephone: (Home).....(Work).....(Cell).....
4. Date of last menstrual period?
5. Have you ever had a previous mammogram? [] Yes [] No
6. Have you ever had breast surgery? [] Yes [] No
7. Has your mother, sister, grandmother or maternal aunt had breast cancer? [] Yes [] No
8. Are you taking any hormones at this time? [] Yes [] No
9. Are you experiencing any new problems with your breasts now? [] Yes [] No
10. When was the last time your breasts were physically examined by a physician?
11. Name of your referring physician

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Daniel Maklansky, M.D.
Alain D. Hyman, M.D.

Jerold Kurzban, M.D.
Barry D. Berson, M.D.

Burton A. Cohen, M.D.
Joseph J. Maklansky, M.D.

Jerald Zimmer, M.D.
Jolinda Mester, M.D.