Mammography Questionnaire – Male Patients

Name: ___________________________ Date of birth: ____________ Age: ______

1. Have you ever had a mammogram before? □ No □ Yes
   If yes, where? ______________________________ Date: ______________

2. Please list any current medications you are taking:
   Medications: ____________________________ What are you taking them for? ____________________________ For how long?
   __________________________________________ ____________________________________________ ____________________________________________
   __________________________________________ ____________________________________________ ____________________________________________
   __________________________________________ ____________________________________________ ____________________________________________

3. Have you ever had breast surgery? □ No □ Yes □ Left Breast □ Right Breast
   Date of surgery: ____________________________

4. Breast problems:
   a. Lump or mass in your breast □ No □ Yes □ Left Breast □ Right Breast
      When was it discovered? __________________________
   b. Breast pain □ No □ Yes □ Left Breast □ Right Breast
      For how long? __________________________
   c. Other current breast problems? □ No □ Yes
      Please explain: ____________________________________________

5. Have you ever been diagnosed with any type of cancer? □ No □ Yes
   If yes, please describe: ____________________________

6. Have any family members been diagnosed with breast cancer? □ No □ Yes
   If yes, please list the family members and their age of diagnosis:
   ____________________________________________

We regret any discomfort you may experience as a result of the breast compression required for your mammogram. The compression improves the images obtained and reduces the amount of radiation exposure. Though a mammogram helps to detect breast cancer, it is important for you to do regular breast self-examinations and see your doctor for physical exams. Approximately 10-15% of breast cancers are not detected by mammograms.

Patient Signature: ____________________________ Date: ____________ Time: ______

Technologist use only:

Tech comments: ____________________________

Technologist Signature: ____________________________ Date: ____________ Time: ______

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