

**MEDICAL CENTER OF LEWISVILLE  
BREAST IMAGING CENTER**

**Report to doctor:**

**Registrar's Initials**

**R2#**

**Tech's initials:**

**NAME:**

**DATE:**

**DATE OF BIRTH:**

**AGE:**

Have you ever had a mammogram?  
If Yes, please indicate where:

Yes      No  
When?

Please circle the appropriate response to the following questions. Where requested, please indicate which breast is affected (Right or Left). All information on this form is held in the strictest confidence. If you have any questions about this form, please ask your technologist.

1. Have you had, or are you presently having:  
Nipple Discharge?  
Tenderness or Pain?  
Breast trauma or infections?

Yes	No	Right	Left
Yes	No	Right	Left
Yes	No	Right	Left

2. Do you currently have a breast lump?

Yes      No

3. Have you had a breast lump in the past?

Yes      No

4. Do you have implants?

Yes      No

5. Have you had a breast operation?  
If Yes. please describe:

Yes      No

6. Have you had a hysterectomy?  
If Not, have you entered Menopause?

Yes      No  
Yes      No

7. Are you currently taking oral contraceptives  
(Birth Control Pill)?

Yes      No

8. Are you taking any other female hormone  
medication?

Yes      No

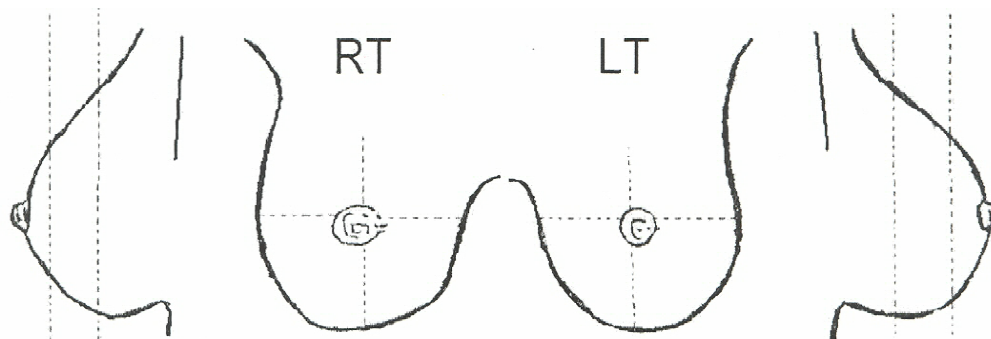
9. Have you ever given Birth?

Yes      No

10. Has your grandmother, mother, sister or daughter  
ever had Breast cancer? (Circle those affected)

Yes      No

Clinical Findings:



**Medical Center of Lewisville**

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**BREAST IMAGING QUESTIONNAIRE**

Patient Identification