VinCon Diagnostic Center 5732 Canton Cove, Winter Springs, FL 32708

Mammography/Breast Ultrasound Questionnaire

PLEASE PRINT

Today's Date:	Your Legal Name:	Date of Birth:	Your Age:	Dr's Name:

1. **Do you have a Family History of Breast Cancer?** N Y (Please circle N or Y)
   If Yes, (____ Mother at age ____) (___ Daughter at age ____) (___ Sister at age ____)
   (____ Other _____ at age(s) _____)
2. **Have you ever had previous breast surgery or procedure?** N Y, If Yes:
   ____ Cyst aspiration Left/Right) Date: _____ Diagnosis:_____
   ____ Biopsy (Left/Right) Date: _____ Diagnosis:_____
   ____ Excisional Biopsy (Left/Right) Date: _____ Diagnosis:_____
   ____ Breast Reduction (Left/Right) Date: _____
   ____ Implants (Left/Right) Date: _____ Please circle: Silicone or Saline?
   ____ Injury to Breast (Left/Right) Date: _____ Due to _____
   ____ Lumpectomy for cancer (Left/Right) Date: _____ Diagnosis _____
   ____ Mastectomy (Left/Right) Date:_____
   ____ Radiation/Chemo (Left/Right) Date: _____
   ____ Non-Hogkins Lymphoma with Radiation to the Chest Wall

REMINDER:
MEDICARE Members:
Please note that Medicare will only pay for this exam once every 12 months.

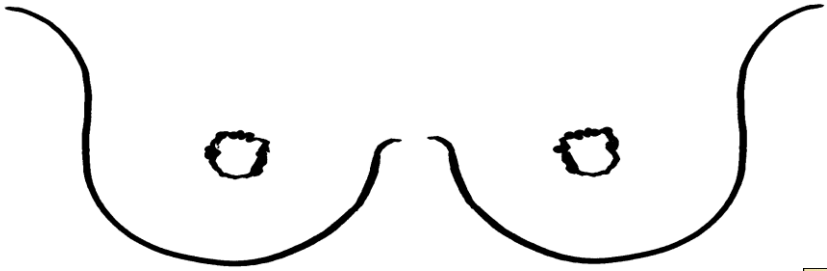
3. **At what age did your menstrual cycles begin? _____**
4. **Are you: ____Pre ____Peri ____Post Menopausal at age: _____**
5. **At what age did you give birth to your first child? _____**
6. **What is your Ethnicity?** ☐ Hispanic ☐ Asian ☐Black ☐ Caucasian ☐Ashkenazi Jewish ☐Other _____
7. **Are you currently taking a cancer preventative medication?** N Y, If yes, Name? _____
8. **Hormone Replacement:** Have you ever been on it? N Y, If Yes, for how long? _____
9. **Are you on Birth Control Drugs?** N Y, If Yes: At what age did you start taking them? _____
10. **Have you had a hysterectomy?** N Y, If Yes, were your ovaries removed? N Y
11. **Have you ever had a mammogram?** N Y, If Yes: Where was it performed? _____
12. **Do you currently have a breast problem?** N Y
13. **Do you have a new breast lump?** N Y, If Yes: How long has it been there? _____
14. **Do you have nipple discharge?** N Y, If Yes: What color is it? _____ How long? _____
15. **How did you hear about our center?** _____

*****PLEASE DO NOT WRITE BELOW THIS LINE*****

TECHNOLOGIST ONLY: _____

Please indicate any of the following using these symbols:

Scar -------
Mole *****
Lump **X**
Pain **P**
Previous Biopsy **B**
Previous Lump Removal **L**



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Technologist Signature