Centre intégré
de santé
et de services sociaux
de la Montérégie-Ouest
Québec

Dossier : _____

Nom, prénom : _____

Date de naissance : _____ ☐ F ☐ M
aaaa/mm/jj

NAM : _____ Exp. _____
aaaa/mm

Nom, prénom de la mère : _____

Installation : _____

MAMMOGRAPHY QUESTIONNAIRE
MEDICAL IMAGING

MEDICAL HISTORY

1. Have you had a mammogram before?
☐ Yes ☐ No Date of last one: yyyy/mm/dd Name of institution: _____

2. Have you had a breast exam during the past year?
☐ Yes ☐ No Done by: _____ ☐ Doctor ☐ Nurse

3. Do you have breast problems that have appeared or worsened over the past two years?

- Pain	☐ Yes	☐ No	☐ Left breast	☐ Right breast
- Nipple discharge	☐ Yes	☐ No	☐ Left breast	☐ Right breast
- Lumps	☐ Yes	☐ No	☐ Left breast	☐ Right breast
- Nipple retraction	☐ Yes	☐ No	☐ Left breast	☐ Right breast
- Nipple eczema	☐ Yes	☐ No	☐ Left breast	☐ Right breast
- Change (skin retraction on the breast)	☐ Yes	☐ No	☐ Left breast	☐ Right breast
- Redness on at least one-third of the breast	☐ Yes	☐ No	☐ Left breast	☐ Right breast
- Other: _____	☐ Yes	☐ No	☐ Left breast	☐ Right breast

4. Have you had a breast procedure before?

- Breast reduction	☐ Yes	☐ No	☐ Left breast	☐ Right breast Year: _____
- Removal of a cancerous tumour	☐ Yes	☐ No	☐ Left breast	☐ Right breast Year: _____
- Mastectomy: ☐ Total ☐ Partial	☐ Yes	☐ No	☐ Left breast	☐ Right breast Year: _____
- Needle biopsy	☐ Yes	☐ No	☐ Left breast	☐ Right breast Year: _____
- Surgical biopsy	☐ Yes	☐ No	☐ Left breast	☐ Right breast Year: _____
- Chemotherapy	☐ Yes	☐ No	☐ Left breast	☐ Right breast Year: _____
- Radiation therapy	☐ Yes	☐ No	☐ Left breast	☐ Right breast Year: _____
- Breast implant replacement	☐ Yes	☐ No	☐ Left breast	☐ Right breast Year: _____

5. Do you have breast implants? ☐ Yes ☐ No ☐ Left breast ☐ Right breast
Since: _____
Position of implant: ☐ Retropectoral ☐ Retroglandular Implant filling: ☐ Silicone ☐ Saline

6. Have you ever had breast implants?
☐ Yes ☐ No ☐ Left breast ☐ Right breast Removed when: _____

7. Is there a history of breast cancer in your family?
☐ Yes ☐ No ☐ I don't know
Age at diagnosis: ☐ Mother _____ ☐ Sister(s) _____/_____ ☐ Daughter(s) _____/_____ ☐ Father: _____

8. Do you take hormone replacement therapy on a regular basis?
Yes ☐ No Since: _____

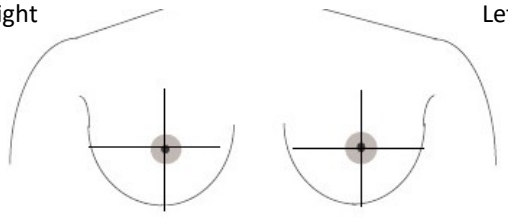
9. Have you ever taken hormone replacement therapy on a regular basis?
☐ Yes ☐ No Stopped when: _____

10. You are menopausal?
Yes ☐ No Since: _____

11. Have you had full-term pregnancies?
☐ Yes ☐ No Age at first pregnancy: _____
Number of children: _____

Physical characteristics
Height: _____ ☐ Estimated ☐ Measured
Weight: _____ kg ☐ Estimated ☐ Measured

SCARS, MOLES, ETC.



Signature of technician: _____ Date: yyyy/mm/dd