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

Dossier : _____

Nom, prénom : _____

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

NAM : _____ Exp. _____ (aaaa/mm)

Nom, prénom de la mère : _____

Installation : _____

MAMMOGRAPHY QUESTIONNAIRE - MEN
MEDICAL IMAGING

MEDICAL HISTORY

1. Have you had any of the following examinations before? ☐ Yes ☐ No

☐ Mammography
☐ Breast ultrasound
☐ Breast magnetic resonance imaging (MRI)

Date of last exam: yyyy/mm/dd Name of institution: _____

2. Have you had a breast exam in the past year? ☐ Yes ☐ No

Done by: _____

3. Do you have breast problems that have appeared or worsened over the past two years? ☐ Yes ☐ No

☐ Pain ☐ Left breast ☐ Right breast
☐ Nipple discharge ☐ Left breast ☐ Right breast
☐ Lump ☐ Left breast ☐ Right breast
☐ Other : _____

4. Have you ever had a breast biopsy? ☐ Yes ☐ No ☐ Left breast ☐ Right breast Year : _____

5. Have you had any of the following cancers? ☐ Yes ☐ No

☐ Testicular Year: _____
☐ Thyroid Year: _____
☐ Kidney Year: _____
☐ Prostate Year: _____
☐ Lung Year: _____

6. Have you had health problems with any of the following? ☐ Yes ☐ No

☐ Testicles
☐ Thyroid gland
☐ Kidneys
☐ Liver
☐ Pituitary gland
☐ Klinefelter syndrome

7. Do you have a family history of breast, ovarian or prostate cancer?

☐ Yes ☐ No ☐ Do not know If yes: ☐ Mother / Father ☐ Sister / Brother ☐ Daughter / Son

Physical characteristics: Height: _____ in/_____ cm **Weight**: _____ kg/_____ lb.

Comments:

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