

Patient Name _____

Birth Date _____ **Today's Date** _____

Mammogram Questionnaire

Do you have **breast implants**? Yes No

Do you have a **lump or mass** in your breast? Yes No Unknown

Have you had a **previous mammogram**? Yes No

If yes, **where** was it done and what was the **date**? _____

If yes and non-Munson/Mercy facility, please provide facility, town, state and ordering physician:

If additional films are needed, **may we call you**? Yes No

If yes, what **phone number** should we call? _____

Do you have a **history of Breast Cancer**? Yes No

Bone Density Questionnaire

What is your weight? _____

Have you had a previous Bone Density? Yes No

If yes, **where** was it done and what was the **date**? _____

Are you **scheduled for any other tests/exams** in the near future? Yes No

If yes, please list test and date: _____

Are you pregnant? Yes No

Do you take a **calcium tablet daily**? Yes No

If yes, please do NOT take calcium on the day of your bone density exam.