# THE IMAGING CENTER OF LAS CRUCES RADIOLOGY

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## Male Mammography Questionnaire

Name: ______________________________ Date: ______________________________

Age: ________ Phone Numbers: Home: ________________ Work: ________________ Cell: ________________

Referring Physician: ______________________________

Previous Breast Imaging Studites: What ________________ When ________________ Where ________________

**PLEASE ANSWER THE FOLLOWING "YES" OR "NO" QUESTIONS WITH A CHECK MARK**

| | YES | NO |
|---|---|---|
| Do you feel a lump in either breast? | ❑ | ❑ |
| If "yes", please indicate which side: | ____Right | ____ Left |
| Have you noticed any discharge from either of your nipples? | ❑ | ❑ |
| If "yes", please indicate which side: | ____Right | ____ Left |
| Do you feel pain in either one of your breasts? | ❑ | ❑ |
| If "yes", please indicate which side: | ____Right | ____ Left |
| Have you ever been diagnosed with breast cancer? | ❑ | ❑ |
| ❑ Left breast ❑ Right breast ❑ Both breasts | | |
| Has anyone in your family ever been diagnosed with breast cancer? | ❑ | ❑ |
| If "yes", whom and at what age were they diagnosed: ______________________________ | | |
| Have you had any surgical breast/chest procedures or treatments? | ❑ | ❑ |
| If yes, What was done and when: ______________________________ | | |
| Did you use deodorant today? | ❑ | ❑ |

Please list all the current medications you are taking: ______________________________

______________________________________________________________

**This section for Technologist to complete**

**Comments:** ______________________________

______________________________

______________________________

**Technologist** ______________________________