Breast Imaging Clinic Questionnaire

Date: _____ Appointment Date: _____

MDA # _____ Appointment Time: _____

Patient Name: Last _____ First _____ MI _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone # _____ Work # _____ Cell # _____

D.O.B. ____/_____/_____ Sex _____ Race _____ Religion _____

Marital Status: _____ Birth State: _____ Birth Country: _____

Next of Kin: _____ Rel. _____ Phone # _____

Emergency Contact: _____ Rel. _____ Phone # _____

Insurance Information

Insurance: _____ Customer Service Phone # _____

Primary Card Holder (PCH): _____ D.O.B. ____/____/____

PCH's Employer Name & Address: _____

Member/Policy # _____ Group # _____

Questionnaire

1. Are you having any problems with your breasts? Yes___ No___ (e.g., lumps or nipple discharge)
2. Have you ever been treated for breast cancer or had any type of breast surgeries? Yes ___ No ___
(Circle: breast reduction, breast implants or breast biopsies)
3. Have you ever had any services at UTMDACC, Mobile and/or satellite location? Yes ___ No ___
4. Is this your first mammogram? Yes ___No (month & year of last mammogram) _____

Physician Information

Doctor's Name: Last _____ First _____

Address: _____ City: _____ State: _____

Zip Code: _____ Office Phone # _____ Office Fax # _____