SDMI STEINBERG DIAGNOSTIC

MALE INTAKE QUESTIONNAIRE MAMMOGRAPHY

First Name _____ Last Name _____ DOB/Age _____

Allergies/Include reaction(s) _____ .

Height _____ Weight _____ Patient# (*Internal Use Only*) _____

REASON FOR EXAM *(Please include symptoms and time frame):*

TECH NOTES *(for internal use only)*:

Tech Initials:

Additional Tech Notes:

CURRENT SYMPTOMS (circle all that apply) **How Long?**

Breast Tenderness/Pain	**YES**	**NO**	**Right**	**Left**	_____
Lumps	**YES**	**NO**	**Right**	**Left**	_____
Nipple Discharge	**YES**	**NO**	**Right**	**Left**	_____
If yes to above, color: _____					
Nipple Retraction	**YES**	**NO**	**Right**	**Left**	_____
Skin Dimpling	**YES**	**NO**	**Right**	**Left**	_____

Is this your first mammogram? ☐ **Yes** ☐ **No** **If no, When/Where?** _____

Have you had a previous Breast ultrasound? ☐ **Yes** ☐ **No** **If yes, When/Where?** _____

Do you have a history of Prostate Cancer? ☐ **Yes** ☐ **No** **If yes, When?** _____

Do you have a history of Testicular Cancer? ☐ **Yes** ☐ **No** **If yes, When?** _____

Do you have a history of smoking? ☐ **Yes** ☐ **No** **If yes,** ☐ **Tobacco** ☐ **Marijuana** ☐ **Vapor**

Do you have a history of Breast Procedures? ☐ **Yes** ☐ **No** **If yes, Describe:** _____

Do you have a personal history of Breast Cancer? ☐ **Yes** ☐ **No** **If yes, Explain:** _____

Do you have a family history of Breast Cancer? ☐ **Yes** ☐ **No** ☐ **Unknown** **If yes, Who:** _____

History of Hormones or Steroid use? ☐ **Yes** ☐ **No** **If yes, Explain:** _____

List of Current Medication(s): _____

I agree that the above information is correct *(Do not sign until after technologist has reviewed):*

Patient Signature: _____ Todays Date: _____