THE UNIVERSITY OF TEXAS
MD Anderson Cancer Center

Making Cancer History®

Please complete the questionnaire in its entirety in order to avoid registration/scheduling delays

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 # _____ Email Address: _____

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: _____

City: _____ State: _____ Zip Code: _____

Member/Policy #_____ Group # _____

QUESTIONNAIRE

1. Do you have an on-body injector? Yes☐ No☐

2. Are you having any problems with your breasts? Yes☐ No☐ (e.g., lumps or nipple discharge)

3. Have you ever been treated for breast cancer or had any type of breast surgeries? Yes☐ No☐
   (Check: ☐ breast reduction ☐ breast implants ☐ breast biopsies)

4. Have you ever had any services at UTMDACC, Mobile and/or satellite location? Yes☐ No☐

5. 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 # _____