

Client Pre-Mammogram Questionnaire (Fillable PDF)

Generated 2025-12-31

Please complete before your appointment.

Your answers may be used to estimate breast cancer risk using validated tools (e.g., Tyrer-Cuzick/IBIS, CanRisk/BOADICEA, Manchester score, Penn II). If you are unsure about any family history details, provide your best estimate.

A. Personal details

Full name:		Preferred:	
Date of birth (DD/MM/YYYY):		Medicare:	
Phone:		Email:	
Address:			
GP (name & practice):			

B. Reason for visit / symptoms

Tick all that apply:

- | | |
|---|--|
| ☐ Routine screening | ☐ Nipple discharge |
| ☐ Family history / risk assessment | ☐ Skin/nipple change |
| ☐ Breast lump | ☐ Other (specify below) |
| ☐ Breast pain | |

Side (if symptoms): ☐ Left ☐ Right ☐ Both

Details (symptoms, duration, location, etc.):

C. Current pregnancy / breastfeeding

Are you currently pregnant? ☐ No ☐ Yes ☐ Unsure

Are you currently breastfeeding? ☐ No ☐ Yes ☐ Unsure

If yes: time of last breastfeeding / pumping:

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D. Personal breast history

Have you ever had breast cancer or DCIS?

☐ No ☐ Yes

If yes: age

Year

Side:

☐ L ☐ R ☐ Both

Treatments received (tick all that apply):

☐ Surgery

☐ Endocrine therapy

☐ Radiotherapy

☐ HER2 therapy

☐ Chemotherapy

☐ Other (specify)

Do you have a history of high-risk breast pathology? (tick any)

☐ Atypical ductal hyperplasia (ADH)

☐ LCIS

☐ Atypical lobular hyperplasia (ALH)

☐ Other (specify)

Tick any procedures you have had and add details (side, year).

• Breast augmentation (implants):

☐ No ☐ Yes

Side:

☐ L ☐ R ☐ Both

Year:

• Breast reduction:

☐ No ☐ Yes

Side:

☐ L ☐ R ☐ Both

Year:

• Benign breast surgery (e.g., cyst excision):

☐ No ☐ Yes

Details:

• Mastectomy:

☐ No ☐ Yes

Side:

☐ L ☐ R ☐ Both

Year:

• Lumpectomy:

☐ No ☐ Yes

Side:

☐ L ☐ R ☐ Both

Year:

• Reconstruction (TRAM/DIEP/implant):

☐ No ☐ Yes

Details:

Have you ever had a breast biopsy?

☐ No ☐ Yes ☐ Unsure

If yes: year(s) and results (if known):

E. Family history of cancer

List blood relatives on BOTH sides. Include cancer type(s) and age at diagnosis (or approximate).

Relative	Side M/P	Cancer type(s)	Age at dx	Bilateral / Male	Alive? Y/N	Notes

Additional family history details / clarifications:

How many sisters do you have?

How many maternal half sisters do you have?

How many paternal half sisters do you have?

How many sisters does your mother have?

How many sisters does your father have?

F. Genetic testing / known familial variants

Have you had genetic testing (e.g., BRCA1/2, multigene panel)?

☐ Yes☐ No

If yes: result

☐ Negative☐ Positive☐ Variant uncertain

Gene(s):Year:

If you know you carry a gene mutation, tick and specify:

☐ BRCA1☐ BRCA2☐ PALB2☐ CHEK2☐ ATM☐ TP53

☐ PTEN☐ CDH1☐ Other:

Is there a known pathogenic variant in the family?

☐ Yes☐ No

Gene & relative:

G. Hormonal and reproductive history

Age at first period (menarche):

Number of pregnancies (gravida):Number of births (para):

Your age at first live birth:

☐ No children

Breastfeeding (months):

Menopause status:

☐ Pre

☐ Peri

☐ Post

☐ Unsure

Age at menopause:

Hormone replacement therapy (MHT):

☐ Never

☐ Current

☐ Past

Type:

☐ Estrogen-only

☐ Combined

Total years:

Oral contraceptive pill (OCP):

☐ Never

☐ Current

☐ Past

Years:

Ovary/uterus surgery:

☐ None

☐ Hysterectomy

☐ Oophorectomy/BSO

☐ Mirena

Year:

H. Other risk factors

Height (cm):Weight (kg):Alcohol (drinks/week):

Smoking:

☐ Never

☐ Former

☐ Current

Cigarettes/day:

Exercise: sessions/week

Prior chest radiotherapy?

☐ Yes

☐ No

Age at RT:

Ashkenazi Jewish ancestry / high-risk ethnicity?

☐ Yes

☐ No

Specify:

• Male breast cancer in family:

☐ No

☐ Yes

☐ Unsure

If yes, who?

• Ovarian/fallopian tube/peritoneal cancer in family:

☐ No

☐ Yes

☐ Unsure

If yes, who?

• Pancreatic cancer in family:

☐ No

☐ Yes

☐ Unsure

If yes, who?

• Prostate cancer (especially high-grade/metastatic) in family:

☐ No

☐ Yes

☐ Unsure

If yes, who?

• Any relative with breast cancer under age 50:

☐ No

☐ Yes

☐ Unsure

• Any person with two breast cancers (bilateral or separate diagnoses):

☐ No

☐ Yes

☐ Unsure

• If you have had breast cancer: was it triple negative (ER-/PR-/HER2-)?

☐ No

☐ Yes

☐ Unsure

• Have you been told you have dense breasts?

☐ No

☐ Yes

☐ Unsure

If yes, BI-RADS:

☐ A

☐ B

☐ C

☐ D

☐ Unknown

I. Previous breast imaging

Please list any previous imaging and where it was performed.

Imaging type	Date	Where	Outcome (if known)
☐ Mammogram ☐ USS ☐ MRI ☐ CEM ☐ Other:			
☐ Mammogram ☐ USS ☐ MRI ☐ CEM ☐ Other:			

J. Confirmation

I confirm the information above is accurate to the best of my knowledge.

Signature:

Date:

Please email your completed form to:

Submit via email

info@noosaradiology.com.au

Noosa Radiology

 90 Goodchap Street, Noosaville QLD 4566



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