



BREAST IMAGING QUESTIONNAIRE

PATIENT I.D.

Patient Name: _____ Birth Date: ____/____/____

Your primary physician: _____ Surgeon: _____
(If applicable)

Reason for exam:

- | | |
|--|--|
| <input type="checkbox"/> Recently diagnosed breast cancer (R____ L____) | <input type="checkbox"/> Breast lump (R____ L____) |
| <input type="checkbox"/> Personal history of breast cancer in the past (R____ L____) | <input type="checkbox"/> Implant problem (R____ L____) |
| <input type="checkbox"/> High risk screening | <input type="checkbox"/> Pain in breast (R____ L____) |
| <input type="checkbox"/> Large lymph nodes under arm | |
| <input type="checkbox"/> Cancer elsewhere | |
| <input type="checkbox"/> Nipple discharge (R____ L____ Color _____) | |
| <input type="checkbox"/> Other: _____ | |

Previous mammogram / Ultrasound:

Yes No Date ____/____/____ Where: _____

If not performed at Cedars, did you bring the exam with you today? Yes No

Previous Breast MRI:

Yes No Date ____/____/____ Where: _____

BREAST SURGICAL HISTORY

Have you ever had any type of breast surgery? Yes No

IF YES, please mark which type(s) below. IF NOT, please continue to the next section.

- | | |
|--|---|
| <input type="checkbox"/> Cyst aspiration:
Which breast(s) _____ When? _____ | <input type="checkbox"/> Mastectomy:
Which breast(s) _____ When? _____ |
| <input type="checkbox"/> Needle biopsy:
Which breast(s) _____ When? _____ | <input type="checkbox"/> Breast reduction:
Which breast(s) _____ When? _____ |
| <input type="checkbox"/> Stereotactic biopsy:
Which breast(s) _____ When? _____ | <input type="checkbox"/> Breast Implants:
Which breast(s) _____ When? _____
Silicone or saline? _____ |
| <input type="checkbox"/> Excisional biopsy:
Which breast(s) _____ When? _____ | Which breast(s) _____ When? _____ |
| <input type="checkbox"/> Lumpectomy:
Which breast(s) _____ When? _____ | <input type="checkbox"/> Implant replacement or removal?:
Which breast(s) _____ When? _____ |



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PATIENT I.D. _____

HISTORY OF CANCER

Have you ever been diagnosed with cancer? Yes No
 Type? _____ Date of diagnosis: _____

Did you undergo treatment? Yes No
 Type? _____ Date of treatment: _____

Do you currently take any of these medications?
 Tamoxifen Yes No Nolvadex Yes No Femara Yes No

Do you have a family history of breast cancer? Yes No
 Relation of family members (mother, grandmother, etc.) _____
 At what age was he / she diagnosed?: _____

HORMONE HISTORY

Have you ever taken any of the following hormones?

Duration (MM / YY - MM / YY)

Oral Contraceptives Yes No _____

Estrogen Yes No _____

Progesterone Yes No _____

Other: _____ Yes No _____

Are you having regular periods? Yes No
 Age of first period? _____ Date of last period? _____

Have you ever been pregnant? Yes No
 How many times? _____ How many live births? _____ Age of first birth _____

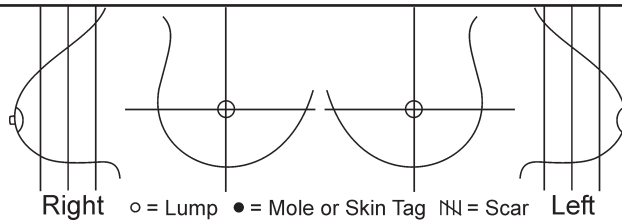
Have you breast fed in the last 6 months? Yes No

Have you had your uterus or ovaries removed? Yes No

Has your weight changed since your last mammogram? Yes No

Are you currently pregnant or trying to become pregnant? Yes No

**(FOR TECHNOLOGIST
USE ONLY)**



NAME OF PATIENT (please print)	SIGNATURE OF PATIENT	DATE	TIME
NAME OF TECHNOLOGIST (please print)	SIGNATURE OF TECHNOLOGIST	DATE	TIME