

BREAST QUESTIONNAIRE: PREVIOUS PATIENT FORM

NAME: _____ DATE: _____ DATE OF BIRTH: _____ AGE: _____ RACE: _____

DAYTIME PHONE: _____ EVENING PHONE: _____ CELL PHONE: _____

REFERRING PHYSICIAN: _____

Are you CURRENTLY having any of the following problems?:

	<u>YES*</u>	<u>NO</u>	<u>RT</u>	<u>LT</u>	<u>BOTH</u>	<u>Date problem began:</u>	<u>HAS THE PROBLEM:</u>							
Breast lump	__	__	__	__	__	_____	__	Resolved	__	Improved	__	Worsened	__	Same
Breast pain or tenderness	__	__	__	__	__	_____	__	Resolved	__	Improved	__	Worsened	__	Same
Breast thickening	__	__	__	__	__	_____	__	Resolved	__	Improved	__	Worsened	__	Same
Skin retraction/change	__	__	__	__	__	_____	__	Resolved	__	Improved	__	Worsened	__	Same
Nipple discharge (clear, bloody)	__	__	__	__	__	_____	__	Resolved	__	Improved	__	Worsened	__	Same
Other: _____														

Are you using any hormones? __No __Yes

Do you have breast implant? __No __Yes __Silicone __Saline

--Have you tested positive for BRCA Test (genetic testing)? Yes__ No ____

--At no charge, would you like to know your lifetime risk assessment of developing breast cancer? Yes__ No ____

Although a woman's risk may be accurately estimated, these predictions do not allow one to say precisely which woman will develop breast cancer and which will not. Up to 80% of patients who develop breast cancer have no risk factors.

**I understand that if I have breast problems, high risk of breast cancer, or questionable mammography, a diagnostic (rather than screening) mammogram must be performed to protect my health and comply with federal requirements. Many insurance companies may apply this cost to my deductible. I have received satisfactory answers to any questions from AWIC staff.*

Let us know changes to your medical history and/or family history of breast cancer:

Patient Acknowledgement and Release

- I have read and reviewed my medical history form and I have completed all questions accurately and completely to the best of my ability.
- I accept full responsibility for all test charges performed in my care.
- I release Angel Williamson Imaging Center (AWIC), its radiologists, and staff from any liability for illness or expenses that I incur due to any inaccurate information that I provide my failure to follow established cancer-screening guidelines and radiologist recommendations, or cancer that cannot be readily seen on mammography, ultrasound, or breast MRI.

 Patient Signature

 Date

FOR MEDICARE PATIENTS ONLY

Are you currently admitted to a skilled nursing facility or rehabilitation center? __No __Yes

If yes, name and phone number of the facility. _____