

BREAST QUESTIONNAIRE

NAME: _____ DATE: _____ DATE OF BIRTH: _____ AGE: _____ RACE: _____
 DAYTIME PHONE: _____ EVENING PHONE: _____ CELL PHONE: _____

Please notify our staff if you have new insurance and/or change of address.

Did your doctor order this mammogram? ___ No ___ Yes If Yes, referring doctor's name: _____

Doctor(s) we should send report to: _____

Have you ever had a mammogram ___ Yes ___ No Where? _____ Year: _____

Films requested by: _____ Faxed Date: _____

Are you **CURRENTLY** having any of the following problems?:

	<u>YES*</u>	<u>NO</u>	<u>RT</u>	<u>LT</u>	<u>BOTH</u>	Date <u>problem began:</u>	<u>YES</u>	<u>NO</u>	
Breast lump	___	___	___	___	___	_____	Are you pregnant?	___	___
Breast pain or tenderness	___	___	___	___	___	_____	Have you ever been pregnant?	___	___
Breast thickening	___	___	___	___	___	_____	Your age of first full term pregnancy	___	___
Skin retraction/change	___	___	___	___	___	_____	Age your periods started: ___ ended: ___	___	___
Nipple discharge (clear, bloody)	___	___	___	___	___	_____			

Other: _____ Are you using any hormones?: Yes ___ No ___

***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.**

Have ever been diagnosed with the following cancer?:

	<u>YES</u>	<u>NO</u>	<u>RIGHT</u>	<u>LEFT</u>	<u>BOTH</u>
Breast	___	___	___	___	___
Uterine	___	___	___	___	___
Ovarian	___	___	___	___	___

Have any blood relatives had history of ovarian cancer?:

	<u>YES</u>	<u>NO</u>	<u>AGE</u>
Mother	___	___	___
Grandmother	___	___	___
Sister	___	___	___
Daughter	___	___	___
Cousin	___	___	___
Aunt	___	___	___
Other	___	___	___

Have any blood relatives, INCLUDING MALE, been diagnosed with breast cancer?: (do not include other cancers)

	<u>YES</u>	<u>NO</u>	<u>AGE</u>
Mother	___	___	___
Grandmother	___	___	___
Sister(s)	___	___	___
Daughter(s)	___	___	___
Cousin(s)	___	___	___
Aunt	___	___	___
Father	___	___	___
Grandfather	___	___	___
Brother	___	___	___
Son	___	___	___
Uncle	___	___	___
Other	___	___	___

--Have you or any first degree blood relatives tested positive for BRCA Test (breast cancer gene)? 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.

Have you had the following?: (please check all that apply to you)

	<u>YES</u>	<u>NO</u>	<u>RIGHT</u>	<u>LEFT</u>	<u>BILATERAL</u>	<u>YEAR</u>	<u>PHYSICIAN/LOCATION</u>
Breast infection/abscess	___	___	___	___	___	___	___
Axillary node removal	___	___	___	___	___	___	___
Cyst aspiration	___	___	___	___	___	___	___
Biopsy	___	___	___	___	___	___	___
Lumpectomy	___	___	___	___	___	___	___
Mastectomy	___	___	___	___	___	___	___
Breast reconstruction	___	___	___	___	___	___	___
Breast reduction	___	___	___	___	___	___	___
Breast radiation	___	___	___	___	___	___	___
Chemotherapy	___	___	___	___	___	___	___
Breast implant	___	___	___	___	___	___	Silicone ___ Saline ___ Both ___
Radiation therapy to the chest	___	___	___	___	___	Year: _____	

List any drug allergies:

Please indicate any current problems using the following symbols on the pictures below:
It is very important that you give us accurate and complete information. Inaccurate or incomplete information can lead to missed diagnosis of cancer or unnecessary surgery.

Moles: •

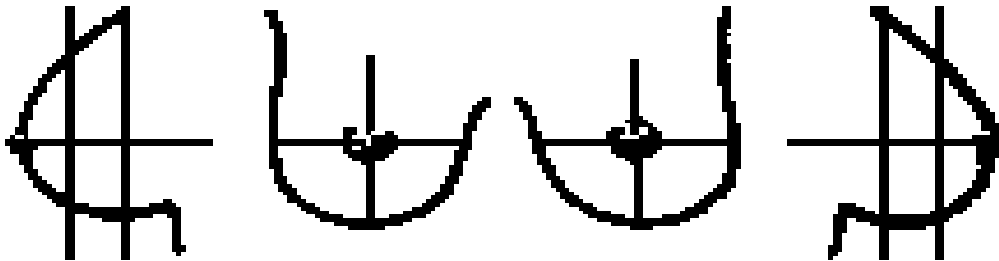
Scars: –

Lumps: Δ

Pain: O

RIGHT

LEFT



Explain: _____

Regular Breast Physical Exam is very important! Radiologists at Angel Williamson Imaging Center do not routinely conduct breast physical exams. You are requested to have annual physical exams with your primary care doctor, and to perform regular breast self-exams. If you need referral to a primary care doctor, AWIC will be happy to help you. Please let our staff know.

Hormone replacement therapy or dense breasts may increase cancer risk: Patients taking hormone replacement therapy and patients with dense breasts are at an increased risk for breast cancer that is difficult to diagnose early.

Mammography and breast ultrasound cannot find all breast cancers: If you have persistent pain, discharge, lump, mass, or any other breast complaint, you are requested to notify AWIC. A surgical consultation may be scheduled to protect your health.

Screening Breast MRI: American Cancer Society recommends, and most insurance companies approve, annual breast MRI screening for patients with more than 20% lifetime risk of breast cancer per Gail and/or Tyrer-Cuzick models.

Patient Acknowledgement and Release

- I have read and understand this questionnaire, and have completed all questions accurately and completely to the best of my ability.
- I agree to schedule regular breast examinations with my primary care doctor, and to perform periodic breast self-examinations.
- 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, and 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. _____
