Angel Williamson IMAGING CENTER
a place for hope, health and happiness

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BREAST QUESTIONNAIRE: ESTABLISHED PATIENT FORM

NAME: ______________________ **DATE:** ____________ **DATE OF BIRTH:** ____________ **AGE:** _____ **RACE:** ________

DAYTIME PHONE:____________________**EVENING PHONE:**____________________**CELL PHONE:**_______________

Are you CURRENTLY having any of the following problems?:

	YES*	NO	RT	LT	BOTH	Date problem began:	HAS THE PROBLEM:			
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: ________________________________

Moles = • Scars= – Lumps = Δ Pain = O

RIGHT **LEFT**

Are you using any hormones/supplements? ___No ___Yes List:____

Do you have breast implant? ___No ___Yes ___ Silicone ___Saline

Date of last mammogram? ____________________ Where?____

*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:

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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. ______________________________________