

HERSPACE
Breast Imaging Questionnaire

Account # _____ Tech _____ Date _____

Name: _____ Age: _____ DOB: _____

Date and Location of last mammogram: _____

For premenopausal women:

Date of last menstrual period _____/_____/_____

Is there a possibility that you may be pregnant? Yes No

Age at first menses _____

Age at menopause, if applicable _____

Latex allergy? . Yes No

Are you of Ashkenazi (eastern European)Jewish descent? Yes No

A. REASON FOR VISIT TODAY:

Prescription from physician indicating a problem or concern? Yes No

Baseline (first) mammogram? Yes No

Routine annual screening Yes **Skip to section B.**

No Check the reason(s) for today's visit below:

Lump R L

Pain R L

Nipple discharge R L

6-month follow-up R L

Abnormal outside mammogram R L

Other _____

B. CLINICAL HISTORY: (place a check next to any that apply)

Lumpectomy for breast cancer R L When? _____

Mastectomy R L When? _____

Radiation therapy to: breast R L
chest head neck

Type of condition? _____ When? _____

Chemotherapy for breast cancer When? _____

Chemotherapy for other malignancy What? _____ When? _____

Tamoxifen Arimidex Femara When? _____ to _____

Implants? R L Silicone Saline year implants placed _____

Previous implants? R L Silicone Saline year implants replaced _____

Reduction? R L what year? _____

Continue on next page

C. OTHER HISTORY(place a check next to any that apply)

Personal history of ovarian cancer

Family history of ovarian cancer Relationship _____ Which side of family, maternal or paternal? _____
Age at onset _____

Family history of breast cancer Relationship Which side of family? Age of Onset Number of breasts involved

1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

Have **YOU** been tested for the breast cancer gene(s)? Yes No

If yes, result: Negative Positive BRCA1 BRCA2

My relative(s) has been tested for the breast cancer gene(s) Who was tested? _____

If yes, result: Negative Positive BRCA1 BRCA2

Are you currently taking Coumadin, heparin, aspirin, Plavix or any other blood thinner? Yes No

If öyesö, please list: _____

Number of years on hormone therapy? _____

Any change in hormone brand or dose since last mammogram? Yes No

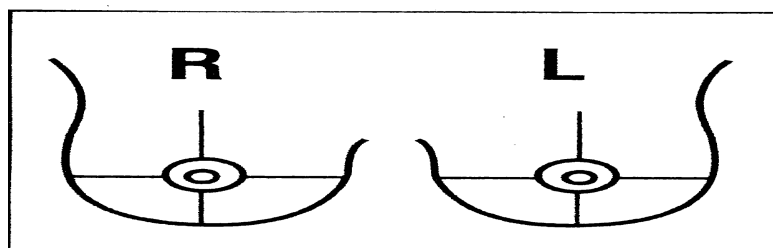
Any known allergies to medication? Yes If so, to what? _____ No

Any other allergies? Yes If so, to what? _____ No

PATIENT SIGNATURE: _____

D. Technologist to complete:

Infection Control Yes



Benign Breast Biopsy? R L What year? _____

Stereotactic or ultrasound guided biopsy? R L What year? _____

Atypical finding on breast biopsy? Yes R L What Year? _____

LCIS (lobular carcinoma in-situ)

ADH (atypical ductal hyperplasia)

Lumpectomy for breast cancer? R L What year? _____