Delaney Radiology

Breast Imaging History Questionnaire

Patient Name:_____ Date of Birth:_____ Age: _____ Weight: _____

Is there any chance that you could be PREGNANT now? ☐ No ☐ Yes

Are you currently breast feeding? ☐ No ☐ Yes

Have you ever had a mammogram before? ☐ No ☐ Yes

If yes, when:_____Where: ☐ Delaney ☐Other Facility _____

Breast Symptoms (Please check any **NEW** symptoms that apply)

☐ None

☐ Lump (side/location): _____

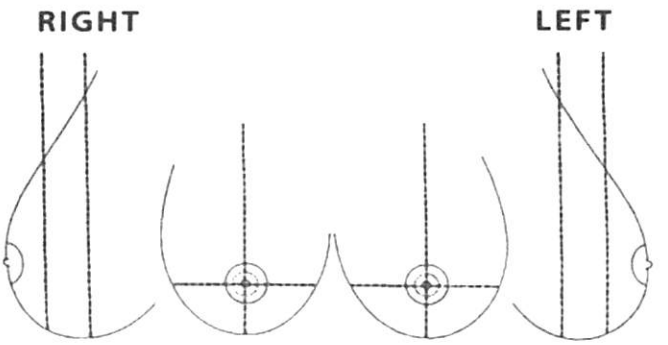
☐ Pain (side/location):_____

☐ Discoloration, redness, or dimpling of the skin:_____

☐ Nipple Discharge (side/color):_____

☐ Nipple Retraction (side/location):_____

☐ Other (please describe):_____



Technologist Notes:

_____

_____

_____

Breast History

Have you ever been diagnosed with breast cancer? ☐ No ☐ Yes

If yes: ☐ Right ☐ Left Did you have: ☐ Chemotherapy ☐ Radiation Therapy ☐ Other:_____

Have you ever had breast procedures? ☐ Yes ☐ No ***If yes, please check the applicable box(es)***

☐ Cyst Aspiration ☐ Biopsy ☐ Lumpectomy ☐ Mastectomy

☐ Reduction ☐ Tissue Expander ☐ Reconstruction

☐ Implants: ☐ Saline ☐ Silicone ☐ Combination

Side of Surgery: ☐ Right Date:_____ ☐ Left Date:_____

Is there a history of Breast Cancer in your family? Please check applicable box(es)

☐ None ☐ Mother ☐ Sister ☐ Daughter Age(s) of Diagnosis: _____

Have you ever been diagnosed/received treatment for any other type of cancer? ☐ No ☐ Yes

If yes, please state type of cancer, treatment, and age at diagnosis: _____

Gynecological History

Are you post-menopausal? ☐ No ☐ Yes

If post-menopausal, what was your age of menopause?_____

Are you currently on Hormone Replacement Therapy? ☐ No ☐ Yes

If you are experiencing any current symptoms or your exam is to follow up a prior breast finding, your mammogram will be coded as a diagnostic procedure (not screening).

Patient Signature _____ Date:_____

Technologist Signature _____ Date:_____