Reston Radiology Consultants

BREAST IMAGING HISTORY QUESTIONNAIRE

Patient Name: _____ **Date:** _____

Is there any chance that you could be PREGNANT now? ☐ YES ☐ NO

Have you ever had a mammogram before? ☐ YES ☐ NO

If yes, WHEN _____ WHERE _____

Breast History:

Are you nursing? ☐ YES ☐ NO

Have you ever had breast cancer? ☐ YES ☐ NO

If so, ☐Right ☐Left and did you have ☐Chemotherapy ☐Radiation Therapy

Have you ever had breast surgery? ☐ YES ☐ NO **(If yes, please check the applicable box(es) below)**

☐ Cyst Aspiration ☐ Biopsy ☐ Lumpectomy ☐ Mastectomy ☐ Reduction ☐ Tissue Expander

☐ Implants: Right Date: _____ ☐Saline ☐ Silicone ☐ Combination ☐ Pre-pectoral ☐ Pro-pectoral

Left Date: _____ ☐Saline ☐ Silicone ☐ Combination ☐ Pre-pectoral ☐ Pro-pectoral

Is there a history of breast cancer in your family? **(Please check boxes if applicable and provide age at diagnosis)**

☐NONE ☐Mother ☐Sister ☐Daughter please provide age(s) of diagnosis_____

Have you had any other type of cancer? ☐ YES ☐ NO

(If yes, describe) _____

Breast Symptoms: (Please check any that apply) ☐NONE

☐Lump: side and location _____

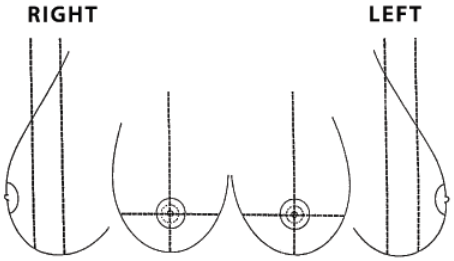
☐Pain: side and location _____

☐Discoloration, Redness, or dimpling of the skin_____

☐Nipple Discharge: side and color _____

☐Nipple Retraction: Side and Location_____

☐Other: please describe _____



Gynecological History:

At what age was your first menstruation? ☐ 11 or earlier ☐ 12-13 ☐ 14 or older

Did you ever take Birth Control Pills? ☐ YES ☐ NO

If yes, please provide start year _____, and end year if stopped _____

Are you still menstruating? ☐ YES ☐ NO If yes, please provide date of start of last menstrual cycle? _____

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

Are you currently on Hormone Replacement Therapy? ☐ YES ☐ NO

Are you currently taking Thyroid medication or Cortisone? ☐ YES ☐ NO If so, please provide_____

Are you taking Tamoxifen? ☐ YES ☐ NO

When did you give birth to your first child? ☐ 19 or earlier ☐ 20-24 ☐ 25-29 ☐ 30+ ☐Never

Do you drink alcohol? ☐ YES ☐ NO If yes, please estimate drinks/week _____

PATIENT SIGNATURE: _____

TECHNOLOGIST SIGNATURE:_____