Breast Imaging Questionnaire

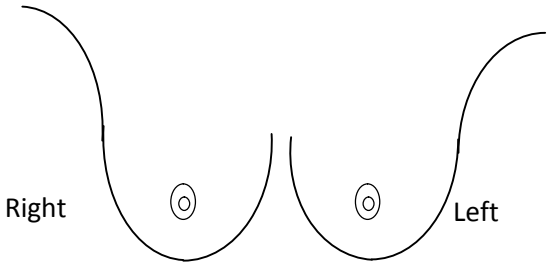
NAME: _____ DATE: _____ Your Age: _____

The date your doctor / nurse last examined your breasts: _____

Have you had a previous mammogram? ❒ YES ❒ NO If yes: When? _____ Where? _____

REASONS FOR TODAY'S EXAMINATION

❒ Routine	❒ RIGHT	❒ LEFT
❒ I Feel Something	❒ RIGHT	❒ LEFT
❒ My Doctor Feels Something	❒ RIGHT	❒ LEFT
❒ Nipple Discharge	❒ RIGHT	❒ LEFT
❒ Pain	❒ RIGHT	❒ LEFT
❒ Other		



If something is felt, please mark it on diagram

Gail Questions

Do you have a medical history of Breast Cancer? ❒ YES ❒ NO ❒ **DCIS** ❒ **LCIS**

History of atypical hyperplasia ❒ YES ❒ NO

Age at first MENSTRUAL period? _____ **Age at first live BIRTH of CHILD?** _____

Have any of the following been diagnosed with ***breast cancer***? ❒ YES ❒ NO

❒ **Self** ❒ **Mother** ❒ **Father** ❒ **Sister** ❒ **Daughter** if so, at what approx. Age: _____

Breast History

Have you ever had?	**(if so, please indicate when)**			
❒ **A Cyst drained**	❒ Right	❒ Left	When:	
❒ **Biopsy, Benign**	❒ Right	❒ Left	When:	How many?
❒ **Biopsy, Cancer**	❒ Right	❒ Left	When:	
❒ **Trauma**	❒ Right	❒ Left	When:	
❒ **Implants**	❒ Right	❒ Left	When:	
❒ **Breast Reduction**	❒ Right	❒ Left	When:	
❒ **Other:**				

ETHNICITY: ❒ **Caucasian (white)** ❒ **African-American** ❒ **Hispanic** ❒ **Asian** **Other**____

Have you ever had?	**BREAST CANCER TREATMENT**			
a mastectomy?	❒ YES	❒ NO	If yes, which side?	❒ RIGHT ❒ LEFT
breast reconstruction?	❒ YES	❒ NO	If yes, which side?	❒ RIGHT ❒ LEFT
radiation therapy to your breast(s)?	❒ YES	❒ NO	If yes, which side?	❒ RIGHT ❒ LEFT
chemotherapy	❒ YES	❒ NO		
a lumpectomy	❒ YES	❒ NO	If yes, which side?	❒ RIGHT ❒ LEFT

Hormone Use

Have you ever used female hormones, such as estrogen **including** birth control? ❒ YES ❒ NO if so, are you presently using them and for how long? ❒ YES ❒ NO Years _____

I hereby authorize Capital Imaging Associates to obtain any follow up results from my physician if needed. I understand this is being done to help maintain Capital Imaging's accreditation by the American College of Radiology and the Federal Mammography Quality Standard Act of '92 (MQSA)

Signature: _____ Date: _____