Orange County Diagnostics

Date: __ /__ /__

BREAST IMAGING QUESTIONNAIRE

Name: _____ **Age:** _____ **Referring Doctor:** _____

Previous mammogram? ❑ No ❑ Yes Year _____ Facility_____

Reason for Exam: ❑ Baseline ❑ Annual ❑ Follow up (❑ LT ❑ RT *Note:*_____)

Are you having problems with your breasts: ❑ No ❑ Yes, If yes, for how many months? _____

If yes, check all that apply: **LUMP** ❑ Left ❑ Right ❑ Both

PAIN ❑ Left ❑ Right ❑ Both

DISCHARGE ❑ Left ❑ Right ❑ Both Type of discharge: _____

Other ❑ Left ❑ Right ❑ Both Other, specify: _____

The following box is very important -- please complete.

At what age was your first menstrual period? _____ **Are you: Pre-, Peri- or Postmenopausal?**
At what age did you have your first child? _____ **(Please circle one above)**

Have you (personally) had breast cancer? ❑ No ❑ Right breast ❑ Left breast ❑ Both breasts **Age** _____

Have you (personally) had ovarian cancer? ❑ No ❑ Yes **Age at diagnosis?** _____

Have any of your blood relatives had breast cancer? ❑ No ❑ Yes ❑ Don't Know How Many? _____

Relation: _____ Maternal/Paternal (circle one) **Diagnosed at what age?** _____
Relation: _____ Maternal/Paternal (circle one) **Diagnosed at what age?** _____
Relation: _____ Maternal/Paternal (circle one) **Diagnosed at what age?** _____

Have any of your blood relatives had ovarian cancer? ❑ No ❑ Yes ❑ Don't Know How Many? _____

Relation: _____ Maternal/Paternal (circle one) **Diagnosed at what age?** _____

If you listed SISTER OR AUNT with breast or ovarian cancer, please give total number of sisters or aunts (include those with and without cancer). ____**Total** # Sisters ____**Total** # Paternal Aunts ____ **Total** # Maternal Aunts

Are you currently taking any hormone replacement therapy (HRT)? ❑ No ❑ Yes **If yes, how long?** _____

Have you had a breast biopsy or breast surgery before? ❑ No ❑ Yes (If yes, check all that apply)

Needle Biopsy ❑ Left ❑ Right ❑ Both LT Date: __ /__ /___ RT Date: ___ /__ /____

How many biopsies have you had? _____

Have you ever had a breast biopsy positive for **atypical hyperplasia**? _____

Mastectomy ❑ Left ❑ Right ❑ Both Date: _____ **Implants** ❑ Left ❑ Right ❑ Both Date: _____

Lumpectomy ❑ Left ❑ Right ❑ Both Date: _____ **Reduction** ❑ Left ❑ Right ❑ Both Date: _____

Other _____ ❑ Left ❑ Right ❑ Both Date: _____

ATTENTION: The radiologist may request that you come back for additional evaluation. The type of additional testing will depend on the type of breast tissue, the finding and the area of concern. Please provide us with the best way to contact you if you need additional testing**. ***** Is it acceptable to leave a message? Please Circle One: Yes No *****

Home Ph: (____) _____-_____ ❑ Day ❑ Evening **Cell:** (____) _____-_____ ❑ Day ❑ Evening

TECHNOLOGIST Comments

_____

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_____

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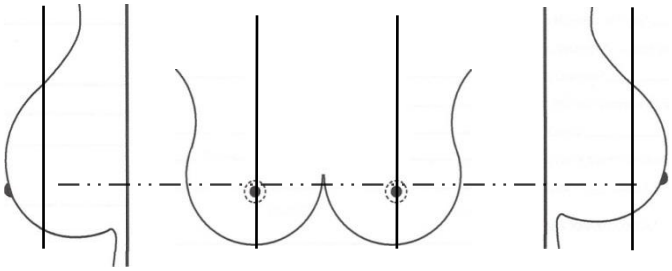
9/21/2015 DA



RIGHT **LEFT**