

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, WHENWHERE		
Breast History:		
Are you nursing?		
Have you ever had breast cancer?		
If so, Right Left and did you have Chemotherapy	y Radiation T	Гhегару
Have you ever had breast surgery? YES NO (If	f yes, please che	ck the applicable box(es) below)
☐ Cyst Aspiration ☐ Biopsy ☐ Lumpectomy ☐ Ma	astectomy R	eduction Tissue Expander
☐ Implants: Right Date: ☐ Saline ☐ Silicone	e Combinati	ion Pre-pectoral Pro-pectoral
Left Date: Saline Silicono	e Combinat	ion 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	e provide age(s)	of diagnosis
Have you had any other type of cancer? YES N	10	
(If yes, describe)		
Breast Symptoms: (Please check any that apply)	IONE	
Lump: side and location		RIGHT L
Pain: side and location		
Discoloration, Redness, or dimpling of the skin		\ \ \
Nipple Discharge: side and color		
Nipple Retraction: Side and Location		
Other: please describe		(6)
Gynecological History:	_	
At what age was your first menstruation?		
Did you ever take Birth Control Pills? YES N		
If yes, please provide start year, and end year if st		
Are you still menstruating? YES NO If yes, pleas	-	f start of last menstrual cycle?
If post-menopausal, what was your age of menopause?		
	☐ YES ☐	
Are you currently taking Thyroid medication or Cortisone?	∐ YES ∐	NO If so, please provide
Are you taking Tamoxifen? YES NO		or ao □ ao □ by
When did you give birth to your first child? 19 or earlies		
Do you drink alcohol? YES NO If yes, please est	imate drinks/wee	ек
PATIENT SIGNATURE:		
TECHNOLOGIST SIGNATURE:		