

EASTSIDE DIAGNOSTIC IMAGING, PLLC**MAMMOGRAPHY / BREAST ULTRASOUND
BREAST MRI / BREAST FNA / CORE BIOPSY**

PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRE

PATIENT NAME:

DOB:

AGE:

Account Number:

SOCIAL SECURITY #:

FEMALE / MALE (PLEASE CIRCLE)

REFERRING PHYSICIAN/PHONE NUMBER:

IF YOU ARE PREGNANT, PLEASE NOTIFY THE TECHNOLOGIST IMMEDIATELY.

ARE YOU OR COULD YOU BE PREGNANT? YES NO _____(INITIAL) DATE OF LAST MENSTRUAL CYCLE: ____/____/____

ARE YOU CURRENTLY BREAST FEEDING? YES NO _____(INITIAL)

AGE AT FIRST PREGNANCY _____ AGE AT LAST PREGNANCY _____ AGE AT MENOPAUSE _____

ARE YOU CURRENTLY TAKING HORMONE REPLACEMENT THERAPY? YES NO IF YES, PLEASE SPECIFY _____

WHEN WAS YOUR MOST RECENT PHYSICAL BREAST EXAM BY A PHYSICIAN? ____/____/____ TECH INITIALS _____

IS THIS A ROUTINE ANNUAL SCREENING? YES NO

HAVE YOU HAD MEMMOGRAPHY BEFORE? YES NO

WAS YOUR PRIOR MAMMOGRAPHY DONE HERE AT EASTSIDE DIAGNOSTIC IMAGING, PLLC? YES NO

IF NO, DID YOU BRING PRIOR FILMS WITH YOU FROM ANOTHER CENTER? YES NO TECH INITIALS _____

HAVE YOU EVER HAD ANY RELEVANT RADIOLOGICAL (BREAST) STUDIES? YES NO IF YES, WHAT KIND? _____

FAMILY AND MEDICAL HISTORY:

FAMILY MEDICAL HISTORY: HAS ANY RELATIVE LISTED BELOW HAD BREAST CANCER? (INDICATE AGE AT ONSET)

MOTHER YES NO AGE AT ONSET: _____

DAUGHTER YES NO AGE AT ONSET: _____

GRANDMOTHER - MATERNAL YES NO AGE AT ONSET: _____

GRAND MOTHER - PATERNAL YES NO AGE AT ONSET: _____

SISTER YES NO AGE AT ONSET: _____

AUNT YES NO AGE AT ONSET: _____

HAVE YOU HAD ANY OF THE FOLLOWING:

DATE

DIAGNOSIS

BIOPSY/NEEDLE ASPIRATION YES NO RIGHT LEFT ____/____/____ _____

BREAST IMPLANT YES NO RIGHT LEFT ____/____/____ _____

BREAST IMPLANT SURGERY YES NO RIGHT LEFT ____/____/____ _____

LUMPECTROMY YES NO RIGHT LEFT ____/____/____ _____

RADIATION YES NO RIGHT LEFT ____/____/____ _____

BREAST REDUCTION YES NO RIGHT LEFT ____/____/____ _____

OTHER YES NO RIGHT LEFT ____/____/____ _____

REASON FOR THIS MAMMOGRAPHY:

DESCRIPTION/COMMENTS

ANNUAL SCREENING YES NO RIGHT LEFT _____

LUMP ON BREAST YES NO RIGHT LEFT _____

PAIN YES NO RIGHT LEFT _____

NIPPLE DISCHARGE YES NO RIGHT LEFT _____

INJURY YES NO RIGHT LEFT _____

OTHER YES NO RIGHT LEFT _____

NONE OF THE ABOVE YES NO RIGHT LEFT _____

HAVE YOU EVER BEEN DIAGNOSED WITH CANCER OR SERIOUS ILLNESS? YES NO

IF YES, WHAT KIND? _____

IF YES, HAVE YOU HAD SURGERY? YES NO IF YES, WHAT KIND? _____

IF YES, HAVE YOU HAD CHEMOTHERAPY? YES NO DATES: ____/____/____

IF YES, HAVE YOU HAD RADIATION THERAPY? YES NO DATES: ____/____/____

PLEASE INDICATE ANY SURGERY, SCARS, MOLES IN THE DIAGRAM BELOW

PICTURE

RIGHT

LEFT

ATTEST THAT THE INFORMATION PROVIDED ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE OF PATIENT OR GUARDIAN OR PERSON AUTHORIZED TO CONSENT FOR PATIENT

DATE

TECHNOLOGIST NOTES:

TECH SIGNATURE