Park Avenue Radiologists, P.C.

PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRE

MAMMOGRAPHY / BREAST ULTRASOUND
BREAST MRI / BREAST FNA / CORE BIOPSY

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 MAMMOGRAM BEFORE? YES NO

WAS YOUR PRIOR MAMMOGRAPHY DONE HERE AT PARK AVENUE RADIOLOGISTS, P.C.? 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 MAMMOGRAM:					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

I 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