

Park Avenue Radiologists, P.C.

**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 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:

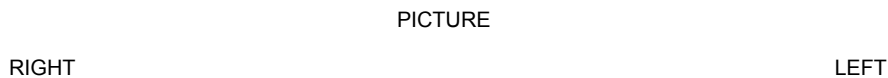
					DATE	DIAGNOSIS
BIOPSY/NEEDLE ASPIRATION	YES	NO	RIGHT	LEFT	____/____/____	_____
BREAST IMPLANT	YES	NO	RIGHT	LEFT	____/____/____	_____
BREAST IMPLANT SURGERY	YES	NO	RIGHT	LEFT	____/____/____	_____
LUMPECTROMY	YES	NO	RIGHT	LEFT	____/____/____	_____
RADIATION	YES	NO	RIGHT	LEFT	____/____/____	_____
BREAST 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



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