Breast Imaging Patient History

AdventHealth

Patient Name: (first & last) _____ Date: _____

Date of Birth: _____ Phone #: _____ Ordering Physician: _____ ☐ N/A

Circle Yes or No. If "Yes," provide explanation.

No Yes 1. Have you had a previous mammogram?
If Yes: When? _____
Where? _____

No Yes 2. Have you had a previous Breast MRI or Breast Ultrasound?
If Yes: When? _____
Where? _____

No Yes 3. Are you having any ***NEW*** areas of pain in your breast(s)?
If Yes: Location (circle): Right Left Both
How long? _____

No Yes 4. Have you or your doctor recently found a ***NEW*** lump or mass in your breast(s)?
If Yes: Location (circle): Right Left Both
How long since detected? _____

No Yes 5. Are you having any ***NEW*** nipple discharge or ***NEW*** puckering of the skin or nipple?
If Yes: Location (circle): Right Left Both
How long? _____

No Yes 6. Have you had any prior breast surgery?
If Yes:
___ Biopsy ___ Right ___ Left Date: _____
___ Aspiration ___ Right ___ Left Date: _____
___ Reduction ___ Right ___ Left Date: _____
___ Implants ___ Right ___ Left Date: _____
___ Injury/Trauma

No Yes 7. Have you ever been diagnosed with breast cancer (do you have a personal history of breast cancer)?
If Yes: Location (circle): Right Left Both
___ Mastectomy Date: _____
___ Lumpectomy Date: _____
___ Chemotherapy # of Treatments: _____
___ Radiation # of Treatments: _____

No Yes 8. Do you have a family history of breast cancer?
If Yes:
___ Mother Age diagnosed: _____
___ Sister Age diagnosed: _____
___ Daughter Age diagnosed: _____
___ Other _____

No Yes 9. Are you taking any hormone replacement?

No Yes 10. Is there any possibility you may be pregnant?

11. What is the date of your last menstrual period?
Estimated Date: _____

TO ALL MAMMOGRAPHY PATIENTS: I understand that:

- Mammograms do not detect all breast cancers. They must be combined with periodic physical exam, monthly breast self-exam, and comparison with any prior mammograms.
- Any time I develop a new breast problem OR if I am having any new breast problems now, it is my responsibility to report this to my physician and also to the technologist at the time of my mammogram.
- If I have been scheduled for a screening mammogram but have a ***new*** breast problem, I may need to have a diagnostic mammogram and/or breast ultrasound, which my physician will need to order.
- I must contact my physician for my final mammogram results.

Date _____ Time _____ Patient/Legally Authorized Person/Care Giver Signature _____ Print Name _____ Relationship _____

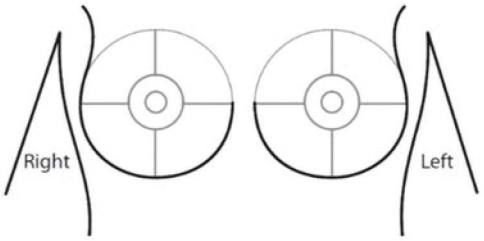
OR ☐ Phone ☐ Video

Qualified Staff / Interpreter Signature _____ Print Qualified Staff / Interpreter Name _____ ID Number _____ Language Interpreted _____

FOR TECHNOLOGIST USE ONLY:

MRN#: _____

Technologist Comments: _____



☐EMR ☐PHYSICIAN SCRIPT ☐SELF-REFERRED

Date _____ Time _____ Technologist Signature _____ Print Name _____

Patient Label or

Patient Name _____

MRN _____