

# Regional Radiology

## PATIENT INFORMATION

**Instructions:** Please fill out this side of the form. Any problems or questions you may have will be answered by the technologist before the exam is performed. Do not be concerned if you cannot answer some of the questions.

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_  
Last First M.I.

Appt. Date: \_\_\_/\_\_\_/\_\_\_ Time: \_\_\_\_\_ Patient Phone #: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Your Referring Physician \_\_\_\_\_  
Name Address Telephone

Have you had a previous **Mammogram**?  Yes  No

If so, when \_\_\_\_\_ where \_\_\_\_\_

What was the date of your last Clinical Breast Exam?  
 (not a mammography) \_\_\_\_\_

Do you have breast implants?  Yes  No

- Silicone     Pre-Pectoral     Retropectoral  
 Saline     Combination     Augmentation

**Family History of Breast Carcinoma:**  None

If you have a family history of breast cancer, mark all that apply and indicate age of onset:

Grandmother    Aunt    Cousin

Maternal:  \_\_\_\_\_ yrs     \_\_\_\_\_ yrs     \_\_\_\_\_ yrs

Paternal:  \_\_\_\_\_ yrs     \_\_\_\_\_ yrs     \_\_\_\_\_ yrs

Mother \_\_\_\_\_ yrs ( Post /  Pre- Menopausal)

Sister \_\_\_\_\_ yrs ( Post /  Pre- Menopausal)

**Personal Breast History:**  None

Indicate if you have had each of the following procedures by marking affected breast:

- | Cyst Aspiration   | <input type="checkbox"/> Left | <input type="checkbox"/> Right | (Date) | _____ | _____ |
|-------------------|-------------------------------|--------------------------------|--------|-------|-------|
| Needle Biopsy     | <input type="checkbox"/> Left | <input type="checkbox"/> Right |        | _____ | _____ |
| Lumpectomy        | <input type="checkbox"/> Left | <input type="checkbox"/> Right |        | _____ | _____ |
| Mastectomy        | <input type="checkbox"/> Left | <input type="checkbox"/> Right |        | _____ | _____ |
| Radiation Therapy | <input type="checkbox"/> Left | <input type="checkbox"/> Right |        | _____ | _____ |
| Breast Reduction  | <input type="checkbox"/> Left | <input type="checkbox"/> Right |        | _____ | _____ |
| Other             | <input type="checkbox"/> Left | <input type="checkbox"/> Right |        | _____ | _____ |

Have you ever had Chemotherapy?  Yes  No

Date \_\_\_\_\_

**Problems:**  None

Indicate if you currently have any of the following by marking affected breast:

	Left	Right
Feel an abnormality	<input type="checkbox"/>	<input type="checkbox"/>
Bloody discharge	<input type="checkbox"/>	<input type="checkbox"/>
Non-bloody discharge	<input type="checkbox"/>	<input type="checkbox"/>
Breast implant problem	<input type="checkbox"/>	<input type="checkbox"/>
Skin thickening or retraction on clinical examination	<input type="checkbox"/>	<input type="checkbox"/>
Lump or thickening	<input type="checkbox"/>	<input type="checkbox"/>
Nipple abnormality	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>

**Other:**

Have you ever had cancer?  Yes  No  
 where? \_\_\_\_\_

Are you pregnant?  Yes  No

Are you currently nursing?  Yes  No

Date of your last period \_\_\_\_\_

Are you menopausal?  Yes  No

Do you take:  
 Birth control pills?  Yes  No \_\_\_\_\_  
Dates of use

Estrogen  Yes  No \_\_\_\_\_

Fertility Pills  Yes  No \_\_\_\_\_

Others  Yes  No \_\_\_\_\_

**Ethnicity:** Check one only – this field is optional and is used only for national statistics

- |   |  |
|---|--|
| <input type="checkbox"/> White            | <input type="checkbox"/> American Indian         |
| <input type="checkbox"/> African American | <input type="checkbox"/> Asian, Pacific Islander |
| <input type="checkbox"/> Other            | <input type="checkbox"/> Hispanic                |