SENTARA®

Breast Imaging Patient Questionnaire

Name _____

DOB _____

REASON FOR EXAM

- ❑ Routine screening/ No current problem
- ❑ Short term follow-up was recommended
- ❑ New problem _____
- ❑ GYN/PCP M.D. _____

Current Weight _____ 10 lbs. ↑ or ↓since last exam? _____

Height _____

HISTORY

1. Y ___ N ___ Is this your first mammogram? If no, where/when did you have your last mammogram _____
2. Y ___ N ___ Do you currently have any of the following?

   ___ Lump/thickening in your breast RT ___ LT ___ ___ Bloody nipple discharge RT ___ LT ___

   ___ Specific area of breast pain RT ___ LT ___ ___ Nipple abnormality (e.g. retraction) RT ___ LT ___
3. Y ___ N ___ Are you Ashkenazi Jewish? (women of Ashkenazi Jewish descent have a higher risk of developing breast cancer)
4. Y ___ N ___ Do you have a Continuous Medication Pump (e.g. insulin pump) or Implanted Stimulator?
5. Y ___ N ___ Have you had any bruises caused by breast trauma in the past year?

OB / GYN

6. Y ___ N ___ Are you pregnant? Last mentrual period _____ Y___ N___ Hysterectomy Y___ N___ IUD
7. Y ___ N ___ Currently nursing or stopped nursing in last 3 months?
8. Y ___ N ___ Are you menopausal? Y___ N___ Birth control (past or current) Y___ N___ Tubal Ligation

Medical History

9. Y ___ N ___ Have you or a family member tested positive for a mutation in the breast cancer gene BRCA1 or BRCA2?
10. Y ___ N ___ *Personal history of breast cancer? Which breast? RT ___ LT ___ When? _____

    Treatment: Lumpectomy/Mastectomy/Radiation/Chemotherapy (circle all that apply) Other _____
11. Y ___ N ___ Prior breast biopsy? Which breast? RT ___ LT ___ Needle or excisional? When? _____
12. Y ___ N ___ Implants/Breast Reduction/ Breast Lift? (circle all that apply) Other _____
13. Y ___ N ___ * Family history of breast, ovarian, or other cancer? Type, which relative(s), age at diagnosis, maternal or paternal

    _____

OB/GYN History

14. Age your period began _____
15. Age at first live birth _____ Number of full term live pregnancies _____
16. Age at menopause _____
17. Y ___ N ___ Hormone therapy? Current or Prior? Dates of use _____ Name/Type _____
18. Additional comments/information: _____

PLEASE INITIAL

_____ Ok to leave phone message: Best Contact Phone Number_____

_____ I, the undersigned, give Sentara Breast Center permission to obtain my prior mammograms, reports, and permission to obtain my confidential records. (follow-up breast surgery, pathology and/or consultation notes)

_____	_____	_____
Print Name	Signature	Date

❑**Medication Pump Removed** ❑**History Reviewed**

Comments _____