Name: _____ Today's Date: _____

Date of Birth: _____ Primary Physician or OB/GYN: _____

Height: _____ **Weight:** _____ Phone Number: _____ May we leave a detail message? ☐ Yes ☐ No

Please answer all questions as completely as you can:

Have you had a previous mammogram? ☐ Yes ☐ No If yes, where and when? _____

Have you given birth? ☐ Yes ☐ No How old were you when you had your first child? _____

Have you gone through menopause? ☐ Yes ☐ No If yes, what age? _____

Age at first menstrual cycle: _____

Have you ever taken hormones? ☐ Yes ☐ No If yes, when and for how long? _____

Is there a possibility you could be pregnant? ☐ Yes ☐ No

Do you have implants? ☐ Yes ☐ No If yes, when was the surgery? _____

Have you had a breast reduction? ☐ Yes ☐ No If yes, when? _____

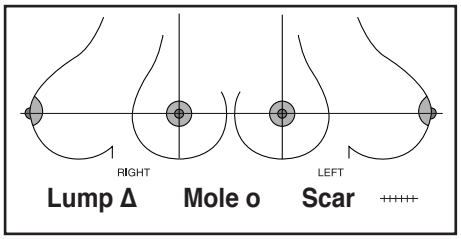
Have you had a breast lift? ☐ Yes ☐ No If yes, when? _____

Are you having any NEW breast related issues? ☐ Yes ☐ No

Which side? ☐ RIGHT ☐ LEFT

Please check all that apply:

☐ Lump: ☐ Rt ☐ Lt ☐ Nipple Discharge: ☐ Rt ☐ Lt ☐ Other: ☐ Rt ☐ Lt _____



History of Breast Cancer

Have you had breast cancer? ☐ Yes ☐ No

If yes, which breast? _____ Number of times? _____ Age at diagnosis: _____

Have you had breast surgery? ☐ Yes ☐ No Which side?

Have you had a breast biopsy? ☐ Yes ☐ No ☐ Rt ☐ Lt Was it a needle biopsy or surgical? _____ ☐ Rt ☐ Lt

Did you have a lumpectomy? ☐ Yes ☐ No ☐ Rt ☐ Lt Did you have a mastectomy? ☐ Yes ☐ No ☐ Rt ☐ Lt

Did you receive chemotherapy? ☐ Yes ☐ No ☐ Rt ☐ Lt Did you receive radiation treatment? ☐ Yes ☐ No ☐ Rt ☐ Lt

Have you had ovarian cancer? ☐ Yes ☐ No If yes, at what age?

Family History

Please indicate if a family member has been diagnosed with breast cancer and what age they were diagnosed:

_____ Mother _____ Sister _____ Daughter _____ Grandmother _____ Aunt

Any history of male breast cancer? ☐ Yes ☐ No If yes, who and at what age? _____

Any ovarian cancer in your family? ☐ Yes ☐ No If yes, who and at what age? _____

Are you of Ashkenazi Jewish Ancestry? ☐ Yes ☐ No

If you are over the age of 50, have you had a colonoscopy? ☐ Yes ☐ No If yes, when? _____

If no, may we follow up with you? ☐ Yes ☐ No

I understand the procedure I am having today.

Signature: _____ Date: _____ Time: _____

Staff Use Only:

IBIS Score: _____

Staff Comments: _____

Staff Signature: _____ Date: _____ Time: _____

Health ONE Rose Medical Center

Patient Information/Label

Breast Questionnaire

RADS
21-9405ROSE (10/14)