PREMIER
MOUNTAIN IMAGING CENTER

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Breast Questionnaire

Date of service: _____ **Ordering Provider:** _____

Patient Name: _____ **DOB:** _____

Personal History:

1. **Date of Last Mammogram:** _____ ☐NORMAL ☐ABNORMAL
   Location/Site:_____

2. **Have you had a prior Breast Ultrasound?** ☐YES ☐NO

3. **Have you had a prior Breast MRI?** ☐YES ☐NO

4. **Reason for today's exam:** (Mark one) ☐Baseline (no prior mammogram) ☐Routine Yearly Exam ☐Short Term Follow-Up ☐Problem-Related
   Current Symptoms? ☐YES ☐NO
   Discovered by: ☐SELF ☐DOCTOR ☐N/A
   Lump? ☐YES ☐NO
   Pain? ☐YES ☐NO
   Nipple Discharge? ☐YES ☐NO
   Other?_____

5. **Are you possibly pregnant?** ☐YES ☐NO

6. **Date of last menstrual cycle:**_____

7. **Date of last physical breast exam:**_____

8. **In the last 6 months, have you taken:** ☐Hormones ☐Birth Control Pills ☐N/A

9. **In the last 6 months, have you**: ☐Breast Feeding ☐Lost Weight ☐N/A

10. **Have you been diagnosed with any of the following?** ☐Breast Cancer ☐Ovarian Cancer ☐LCIS ☐Atypical Hyperplasia ☐Other:_____ ☐N/A

Patient Name: _____ **DOB:** _____

Personal Surgical History:

Previous Breast Procedures? ☐YES, choose below ☐NO

Cyst Aspiration ☐	RT ☐	LT ☐	Date:	Benign ☐	Malignant ☐
Needle(Core) Biopsy ☐	RT ☐	LT ☐	Date:	Benign ☐	Malignant ☐
Biopsy in Radiology Suite ☐	RT ☐	LT ☐	Date:	Benign ☐	Malignant ☐
Biopsy in Operating Room ☐	RT ☐	LT ☐	Date:	Benign ☐	Malignant ☐
Breast Reduction or Lift ☐	RT ☐	LT ☐	Date:		
Implants ☐	RT ☐	LT ☐	Date:	Saline ☐	Silicone ☐
Malignant Lumpectomy ☐	RT ☐	LT ☐	Date:	Radiation ☐	Chemotherapy ☐
Mastectomy ☐	RT ☐	LT ☐	Date:	Radiation ☐	Chemotherapy ☐

Family Medical History:

I. **Has anyone in your family been diagnosed with Breast Cancer?** ☐YES, choose below ☐NO

If Yes, specify whom and give age of diagnosis (include maternal and paternal): Mother☐____ Sister☐____ Grandmother☐____ Father☐____ Aunt☐____ Cousin☐____ Daughter☐____

II. **Has anyone in your family been diagnosed with Ovarian Cancer?** ☐YES ☐NO

I have personally completed the above questionnaire. Should the results of my mammogram require any type of surgical follow-up, I authorize Premier Mountain Imaging Center to obtain pathology results from my doctor, hospital and/or surgeon in accordance with FDA under MQSA guidelines.

_____ _____

Patient Signature (or person authorized to sign): Date:

_____

Relationship to patient if signing for patient:

Office Use Only: Tech Initials:_____

Prior Images: ☐ None-Baseline ☐ Yes - Sent w/ current study ☐ Unavailable_____

Tech Notes:_____

_____# of images:_____