SDMI STEINBERG DIAGNOSTIC

INTAKE QUESTIONNAIRE MAMMOGRAPHY

First Name _____ Last Name _____

Age _____ Height _____ Weight _____

REASON FOR YOUR EXAM: ☐ **Annual Screening** ☐ **Diagnostic**
If Diagnostic, describe symptoms: _____

_____

_____

☐ **By checking this box the below signed agrees to receive their follow up Mammogram Letter via Email.**

TECH NOTES *(for internal use only)*:

Patient Number:	
Tech Initials:	

Additional Notes: _____

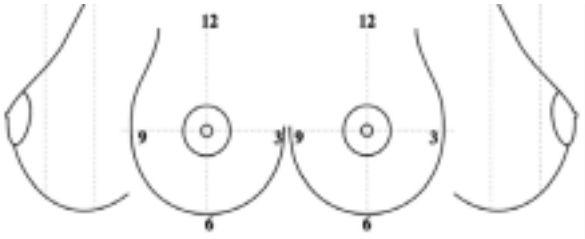
_____

_____

CURRENT SYMPTOMS (circle all that apply)

Breast Tenderness/Pain	**YES**	**NO**	**Right**	**Left**
Lumps	**YES**	**NO**	**Right**	**Left**
Nipple Discharge	**YES**	**NO**	**Right**	**Left**
Nipple Retraction	**YES**	**NO**	**Right**	**Left**
Skin Dimpling	**YES**	**NO**	**Right**	**Left**

TECH ONLY to Complete Diagram



Is this your first mammogram	**YES**	**NO**	**If no, when/where was your last:** _____
Have you had a breast ultrasound	**YES**	**NO**	**When/Where:** _____
Have you had your ovaries removed	**YES**	**NO**	**If Yes, Year Removed:** _____
Have you had a hysterectomy	**YES**	**NO**	**If Yes, Skip next 3 questions.**
Are you pregnant	**YES**	**NO**	**If Yes, MUST inform technologist before exam.**
Are you currently breastfeeding	**YES**	**NO**	
Are you still having menstrual periods	**YES**	**NO**	**Date of last cycle:** _____
			Age of first menstrual cycle: _____
Are you peri-menopausal/menopausal	**YES**	**NO**	

Number of Pregnancies: _____ **Number of Live Births:** _____ **Age of First Pregnancy:** _____

Are you taking hormones or birth control	**YES**	**NO**	**Type/How Long:** _____
Do you have breast implants	**YES**	**NO**	**Saline** **Silicone** **Date Implanted:** _____
Are you Ashkenazi Jewish inheritance	**YES**	**NO**	

Have you ever been diagnosed with Breast Cancer? **YES** **NO**

What type of breast cancer? _____ **Location:** _____

Current status *(circle one)*: **Newly Diagnosed** **Remission** **Recurrence** **Date Diagnosed:** _____

Treatments *(circle)*: **Surgery** **Radiation** **Chemo** **Tamoxifen** **Armedex**

Date of Last Treatment: _____ **Has it spread? YES NO** **If yes, where?** _____

Have you ever been diagnosed with any of the following cancers *(please check all that apply)*:

☐ **Ovarian Cancer** ☐ **Uterine Cancer** ☐ **Cervical Cancer**

Continued on Next Page

SDMI STEINBERG DIAGNOSTIC

INTAKE QUESTIONNAIRE MAMMOGRAPHY

Previous Breast Health Surgeries, Procedures or Imaging			
Type *(ie: Cyst Aspiration, Biopsy, Lumpectomy, Mastectomy, Reduction, Mammogram, Ultrasound, etc.)*	**Side: R/L/ Both**	**Outcome/Results** *(ie: Atypia,Lobular Ductal Hyperplasia, Atypical Ductal Hyperplasia, Lobular Carcinoma In Situ)*	**Date**

Do you have a family history of Breast Cancer: **YES NO**

If yes, indicate age of diagnosis next to family member: Sister _____ **Daughter** _____ **Mother** _____

Paternal Grandmother _____ **Maternal Grandmother** _____ **Other** _____

Do you have a family history of Ovarian, Uterine or Cervical Cancer: **YES NO**

If yes, indicate family member, type and age of diagnosis: _____

Have you ever been tested for the BRCA Gene? **YES NO**

If Yes, please indicate results: BRCA 1 ☐ **Pos** ☐ **Neg** **BRCA 2** ☐ **Pos** ☐ **Neg**

Have any of your relatives been tested for the BRCA Gene? **YES NO**

If Yes, list results: _____

I understand that 10-20% of all breast cancers are not visualized on Mammograms.
I will be responsible for follow-up with my health care provider regarding all future breast concerns.

☐ **I Accept** ☐ **I Decline**

I agree that the above information is correct *(Do not sign until after technologist has reviewed):*

Patient Signature: _____ Todays Date: _____