SDMI STEINBERG DIAGNOSTIC

INTAKE QUESTIONNAIRE MAMMOGRAPHY

First Name _____ Last Name _____ DOB/Age _____

Allergies/Include reaction(s) _____

Height _____ Weight _____ Patient# (*Internal Use Only*) _____

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

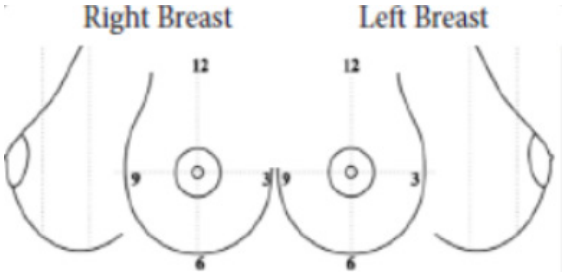
TECH NOTES *(for internal use only)*:

Tech Initials:	
Additional Tech Notes:	

CURRENT SYMPTOMS (circle all that apply) **How Long?**

Breast Tenderness/Pain	**YES**	**NO**	**Right**	**Left**	_____
Lumps	**YES**	**NO**	**Right**	**Left**	_____
Nipple Discharge	**YES**	**NO**	**Right**	**Left**	_____
If yes to above, color: _____					
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 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: _____ **Age of Menopause:** _____

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**	**Are you a smoker?** *(Circle one)* **Current Past Never**

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 one)*: **Surgery Radiation Chemo Tamoxifen Armedex**

Date of Last Treatment: _____ **Has it spread?** *(Circle one)* **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** ☐ **Other:** _____

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Previous Breast Surgeries, Procedures or Breast MRI's			
Type *(ie: Cyst Aspiration, Biopsy, Lumpectomy, Mastectomy, Breast Reduction, Breast Lift, Breast Implant Removal, etc.)*	**Side: R/L/ Both**	**Outcome/Results** *(ie: Normal/Abnormal)*	**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: _____