COOKEVILLE REGIONAL MEDICAL CENTER

BREAST QUESTIONNAIRE

NAME: _____ DATE OF BIRTH: _____

HAVE YOU RECENTLY HAD A MAMMOGRAM? ❑ YES ❑ NO
HOW LONG AGO? _____ WHAT FACILITY? _____
HAVE YOU RECENTLY HAD AN ULTRASOUND? ❑ YES ❑ NO
HOW LONG AGO? _____ WHAT FACILITY? _____
HAVE YOU EVER HAD CANCER? ❑ YES ❑ NO WHAT TYPE? _____
DID YOU RECEIVE CHEMOTHERAPY? ❑ YES ❑ NO RADIATION? ❑ YES ❑ NO
DATE OF THE FIRST DAY OF LAST MENSTRUAL CYCLE? _____
PREFERABLE SCAN TIME IS 7 –12 DAYS AFTER FIRST DAY OF CYCLE
ARE YOU POST MENOPAUSE? ❑ YES ❑ NO
HAVE YOU HAD A HYSTERECTOMY? ❑ YES ❑ NO IF YES WHAT AGE_____
DO YOU TAKE HORMONE THERAPY ❑ YES ❑ NO WHAT TYPE? _____
ARE YOU TAKING BIRTH CONTROL? ❑ YES ❑ NO

FAMILY HISTORY OF CANCER		**IF YES, WHAT TYPE?**
❑ MOTHER	❑ YES ❑ NO	_____
❑ SISTER	❑ YES ❑ NO	_____
❑ DAUGHTER	❑ YES ❑ NO	_____
❑ GRANDMOTHER	❑ YES ❑ NO	_____
❑ AUNT	❑ YES ❑ NO	_____
❑ COUSIN	❑ YES ❑ NO	_____
❑ OTHER explain:		_____

IF MOTHER OR SISTER HAD BREAST CANCER, WAS IT BEFORE OR AFTER MENOPAUSE? _____
HAVE YOU EVER HAD SURGERY ON YOUR BREAST? ❑ YES ❑ NO WHAT FACILITY? _____

FACILITY		LEFT	RIGHT	DATE
_____	❑ NEEDLE BIOPSY	_____	_____	_____
_____	❑ NEEDLE ASPIRATION	_____	_____	_____
_____	❑ SURGICAL BIOPSY	_____	_____	_____
_____	❑ STEREOTACTIC BIOPSY	_____	_____	_____
_____	❑ MASTECTOMY	_____	_____	_____
_____	❑ LUMPECTOMY	_____	_____	_____
_____	❑ REDUCTION	_____	_____	_____
_____	❑ IMPLANTS	_____	_____	_____
_____	❑ TISSUE EXPANDERS	_____	_____	_____

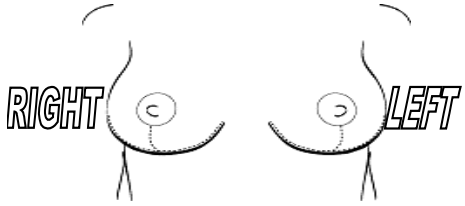
Please explain why your doctor has ordered this MRI and any problems you are currently experiencing? _____

_____

_____

_____ _____ _____
MRI Tech Date Time

PATIENT ID STICKER



MARK ANY SUSPICIOUS AREAS

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