CEDARS-SINAI®
S. MARK TAPER FOUNDATION
IMAGING CENTER

BREAST IMAGING QUESTIONNAIRE

PATIENT I.D.

Patient Name: _____ Birth Date: _____/_____/_____

Your primary physician: _____ Surgeon: _____
(If applicable)

Reason for exam:

- ❑ Recently diagnosed breast cancer (R____ L____)
- ❑ Personal history of breast cancer in the past (R____ L____)
- ❑ High risk screening
- ❑ Large lymph nodes under arm
- ❑ Cancer elsewhere
- ❑ Nipple discharge (R____ L____ Color _____)
- ❑ Other: _____
- ❑ Breast lump (R____ L____)
- ❑ Implant problem (R____ L____)
- ❑ Pain in breast (R____ L____)

Previous mammogram / Ultrasound:

❑ Yes ❑ No Date _____/_____/_____ Where: _____

If not performed at Cedars, did you bring the exam with you today? ❑ Yes ❑ No

Previous Breast MRI:

❑ Yes ❑ No Date _____/_____/_____ Where: _____

BREAST SURGICAL HISTORY

Have you ever had any type of breast surgery? ❑ Yes ❑ No

IF YES, please mark which type(s) below. IF NOT, please continue to the next section.

- ❑ Cyst aspiration:
  Which breast(s) _____ When? _____
- ❑ Needle biopsy:
  Which breast(s) _____ When? _____
- ❑ Stereotactic biopsy:
  Which breast(s) _____ When? _____
- ❑ Excisional biopsy:
  Which breast(s) _____ When? _____
- ❑ Lumpectomy:
  Which breast(s) _____ When? _____
- ❑ Mastectomy:
  Which breast(s) _____ When? _____
- ❑ Breast reduction:
  Which breast(s) _____ When? _____
- ❑ Breast Implants:
  Which breast(s) _____ When? _____
  Silicone or saline? _____
  Which breast(s) _____ When? _____
- ❑ Implant replacement or removal?:
  Which breast(s) _____ When? _____

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PATIENT I.D.

HISTORY OF CANCER

Have you ever been diagnosed with cancer? ❑ Yes ❑ No

Type? _____ Date of diagnosis: _____

Did you undergo treatment? ❑ Yes ❑ No

Type? _____ Date of treatment: _____

Do you currently take any of these medications?

Tamoxifen ❑ **Yes** ❑ **No** Nolvadex ❑ **Yes** ❑ **No** Femara ❑ **Yes** ❑ **No**

Do you have a family history of breast cancer? ❑ Yes ❑ No

Relation of family members (mother, grandmother, etc.)

At what age was he / she diagnosed?: _____

HORMONE HISTORY

Have you ever taken any of the following hormones?

			Duraction (MM / YY - MM / YY)
Oral Contraceptives	❑ Yes	❑ No	_____
Estrogen	❑ Yes	❑ No	_____
Progesterone	❑ Yes	❑ No	_____
Other: _____	❑ Yes	❑ No	_____

Are you having regular periods? ❑ Yes ❑ No

Age of first period? _____ Date of last period? _____

Have you ever been pregnant? ❑ Yes ❑ No

How many times? _____ How many live births? _____ Age of first birth _____

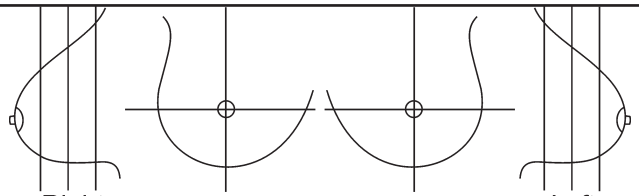
Have you breast fed in the last 6 months? ❑ Yes ❑ No

Have you had your uterus or ovaries removed? ❑ Yes ❑ No

Has your weight changed since your last mammogram? ❑ Yes ❑ No

Are you currently pregnant or trying to become pregnant? ❑ Yes ❑ No

(FOR TECHNOLOGIST USE ONLY)



NAME OF PATIENT (please print)	SIGNATURE OF PATIENT	DATE	TIME
NAME OF TECHNOLOGIST (please print)	**SIGNATURE OF TECHNOLOGIST**	**DATE**	**TIME**