SISKIYOU imaging

MR Breast Questionnaire

Name: _____ Birth Date: ___/___/___

Primary Physician: _____ Surgeon: _____ Next appointment: ___/___/___

Reason for Exam:

___implant problem (☐ right ☐ left)
___breast lump or thickening (☐ right ☐ left)
___nipple discharge or abnormality (☐ right ☐ left)
___enlarged lymph glands under arm
___known breast cancer (☐ right ☐ left)
___other: _____

Are you currently pregnant or breast-feeding? ☐ Yes ☐ No

Are you still menstruating? ☐ Yes ☐ No If yes, first day of last menstrual period ___/___/___

Normal cycle length (days from one period to the next): _____

Have you taken hormones? (birth control or hormone replacement) ☐ Yes ☐ No
Type: _____ When did you stop? ___/___/___

Family history of breast cancer?
Mother ____ Aunt____ Sister ___ Grandmother ___ Daughter ___

History of breast cancer gene carrier? ☐ Yes ☐ No

History of previous Hodgkin's Lymphoma? ☐ Yes ☐ No

If yes, please describe previous treatment _____

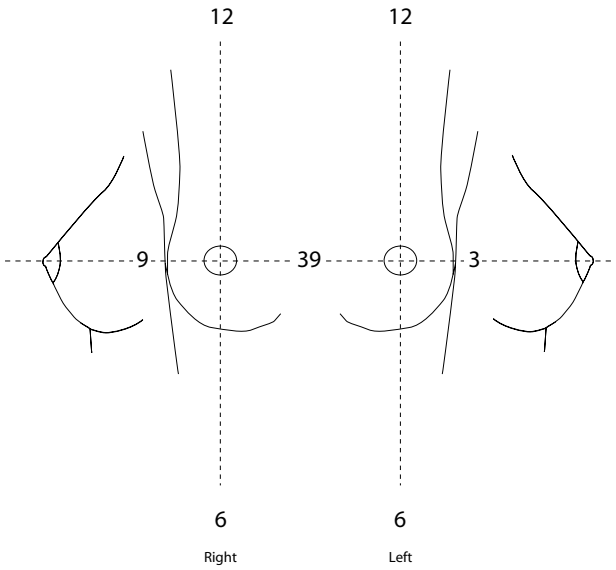
Previous mammogram: ☐ Yes ☐ No Date ___/___/___ Where? _____

Previous ultrasound: ☐ Yes ☐ No Date ___/___/___ Where? _____

Have you had any of the following?

	Left	Right	Date and Results (where applicable)
Cyst aspiration	☐	☐	_____
Needle biopsy	☐	☐	_____
Surgical biopsy	☐	☐	_____
Lumpectomy for cancer	☐	☐	_____
Radiation therapy	☐	☐	_____
Chemotherapy	☐	☐	_____
Implants	☐	☐	_____
Breast reduction surgery	☐	☐	_____
Mastectomy	☐	☐	_____

Please show location of any breast lumps or surgery sites.



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A partnership of Ashland Community Hospital, Rogue Valley Medical Center and Southern Oregon Radiology Associates.