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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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 ________

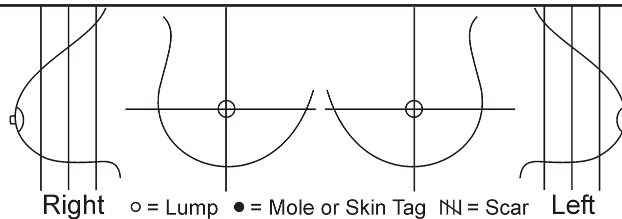
Have you breast fed in the last 6 months? ❑ Yes ❑ No

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