Breast CT Patient Questionnaire

PRINTED NAME:		**Patient ID:**	
		Date of service:	

RACE / ETHNICITY:	**Please circle**		
Hispanic or Latino	American Indian or Alaska	Asian	Russian
Ashkenazi Jew	Black	White	Other:

LAST NAME	**FIRST NAME**	**AGE**	**DATE OF BIRTH**

Previous Mammograms **Yes / No**

If yes, when and where:

Reason for today's visit	Routine / Annual New Problem	Short term follow up Please Describe:	

Family History

Has any blood relative had breast cancer or ovarian cancer? If so, please indicate each relative and their relationship to you.			
Relationship:	Age of Diagnosis:	Maternal / Paternal	Breast / Ovarian
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HORMONE THERAPY	Estrogen, Progesterone, Birth Control	How Long?
Currently on Hormone Treatment	Yes / No	
Are you Pregnant / Breastfeeding	Yes / No	

Personal History

Have you ever had breast cancer?	Yes / No	Left / Right	Date:
Are you BRCA mutation (+)?	Yes / No		
Is anyone in your family BRCA positive or any other mutation postive?		Yes / No	
Have you had any type of cancer?	Yes / No	Type:	Date:

	Side Date		
Benign Surgical Biopsy / Excisional	L / R Date	Breast Reduction	L / R Date
Cyst Aspiration	L / R Date	Breast Lift	L / R Date
MRI Biopsy	L / R Date	Lumpectomy	L / R Date
Ultrasound Biopsy-Needle	L / R Date	Mastectomy	L / R Date
Stereotactic biopsy	L / R Date	Breast Implants	L / R Date
Chemotherapy	L / R Date	Radiation	L / R Date

Patient Signature: _____

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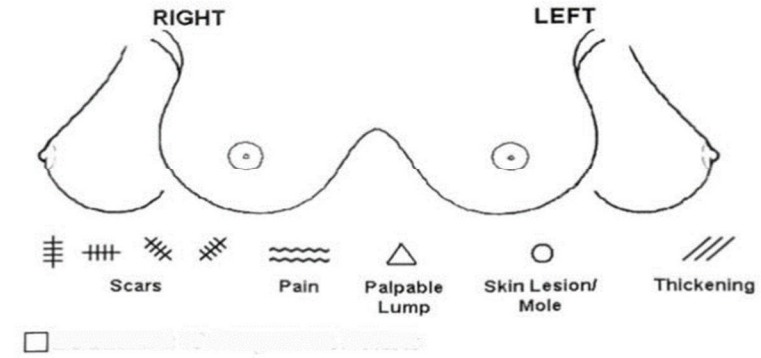

Technologist Notes: _____

Technologist _____ # of Images _____