Advanced Imaging Centers | Ocala Health

BREAST HISTORY QUESTIONNAIRE

Name: ____ **Date of Birth** _________________

Referring Doctor: ____

Tech Use ONLY: ____

PLEASE CIRCLE YES OR NO TO EACH QUESTION

Question			
Have **YOU** had previous mammograms**?**	**Yes**	**No**	
Where? _______________________ When? ___________			
Have **YOU** given birth?	**Yes**	**No**	
YOUR age when first child was born: _________________			
What was **YOUR** age at first menstrual period? _____________			
Have **YOUR** menstrual periods stopped?	**Yes**	**No**	
What age did **YOUR** menstrual period stop? ________			
Had a Hysterectomy?	**Yes**	**No**	If yes, at age _________
Ovaries removed?	**Yes**	**No**	If yes, at age _________
Are you taking hormones **NOW**?	**Yes**	**No**	For how long? ___________
Have you taken hormones in the **PAST?**	**Yes**	**No**	For how long? ___________
Have you had chest radiation for Hodgkins lymphoma?	**Yes**	**No**	
Have **YOU** had ovarian cancer or colon cancer?	**Yes**	**No**	Age at diagnosis: _________

FOR PATIENTS WHO HAVE HAD BREAST CANCER:

Have **YOU** had breast surgery for **CANCER?** **Yes** **No**

- Needle Biopsy (Cancer) Left Date: _________ Right Date: _________
- Lumpectomy (Cancer) Left Date: _________ Right Date: _________
- Mastectomy (Cancer) Left Date: _________ Right Date: _________

Have **YOU** had breast surgery that was **NOT** for cancer? **Yes** **No**

- Needle Biopsy Left Date: _________ Right Date: _________
- Surgical Biopsy Left Date: _________ Right Date: _________
- Lumpectomy Left Date: _________ Right Date: _________
- Breast Reduction Left Date: _________ Right Date: _________
- Breast Implants Left Date: _________ Right Date: _________

***Please Circle if the following RELATIVES have had Breast, Ovarian, Colon Cancer:**

- **Mother:** Breast Ovarian Colon Age at diagnosis:________
- **Sister:** Breast Ovarian Colon Age at diagnosis:________
- **Daughter:** Breast Ovarian Colon Age at diagnosis:________
- **Father:** Breast → Colon Age at diagnosis:________

Patient Signature: ____ **Date**: _________________

By signing above, I am confirming that my past medical history has been documented correctly and I agree with the information documented.