Beth Israel Deaconess Hospital
Needham
148 Chestnut Street
Needham, MA 02492

PATIENT'S NAME _____

MED. REC. # _____

DOB _____

Patient Identification

INTEGRATED BREAST CARE CENTER PATIENT QUESTIONNAIRE

Date: ___/___/___

MR1927

Best daytime number: ( ) _____ - _____ Alternate number: ( ) _____ - _____

Referring Clinician: _____

Reason for Today's Exam: ☐ Routine ☐ Other: _____

Previous Mammograms: ☐ No ☐ Yes When: ___/___/___ Where: _____

Previous Breast MRI: ☐ No ☐ Yes When: ___/___/___ Where: _____

Have you had a recent breast exam by your clinician? ☐ No ☐ Yes Findings: _____

Have you had weight gain or loss since last mammogram? ☐ No ☐ Yes Amount gained / lost: _____

Previous Breast Surgery: ☐ No ☐ Yes ***If Yes,*** continue answering:

	Right	Left	When:	Result:
Breast Biopsy	☐	☐	___/___/___	_____
Breast Aspiration	☐	☐	___/___/___	_____
Mastectomy / Lumpectomy for cancer	☐	☐	___/___/___	_____
Radiation Therapy	☐	☐	___/___/___	_____
Breast Implants	☐	☐	___/___/___	_____
Other Breast Surgery	☐	☐	___/___/___	_____

Medical History:

Age Menstruation Began: _____ Last Period: ___/___/___ Age at Menopause: _____

Are you a known breast cancer mutation carrier? ☐ No ☐ Yes ☐ Unknown – not tested

Have you ever been pregnant? ☐ No ☐ Yes ***If Yes,*** Age at first full-term pregnancy: _____

Number of Pregnancies: _____ Number of Children: _____

Hysterectomy? ☐ No ☐ Yes When: ___/___/___

Ovaries removed? ☐ No ☐ Yes When: ___/___/___

Birth Control Pills? ☐ No ☐ Now ☐ Previously: Age at start? ____ Length Time / Years: ____

Fertility medication? ☐ No ☐ Now ☐ Previously: Age at start? ____ Length Time / Years: ____

Post-menopausal hormone replacement? ☐ No ☐ Now ☐ Previously: Age at start? ____ Length Time / Years: ____

Tamoxifen? ☐ No ☐ Now ☐ Previously: Age at start? ____ Length Time / Years: ____

Cancer History:

Does anyone in your family have a history of:	No	Yes	Personal History	Relative	Mother / Father side	Age of diagnosis
Breast cancer	☐	☐	☐			
Ovarian cancer	☐	☐	☐			
Other cancer: _____	☐	☐	☐			
Other cancer: _____	☐	☐	☐			

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Optional Question: *We ask because this information helps determine your risk of breast cancer more accurately

What is your race / ethnicity? ☐ African American ☐ Alaskan Native ☐ American Indian ☐ Asian American ☐ Hispanic ☐ White ☐ Unknown

X_____ _____ **OR**
Patient's Signature Print Name

X_____ _____ **and** _____
Signature of Person authorized to sign for patient Print Name Relationship to patient

Date: ____/____/____ **Time:** __ __ : __ __ ○ a.m. ○ p.m.

DO NOT WRITE BELOW THIS LINE – FOR TECHNOLOGIST USE ONLY

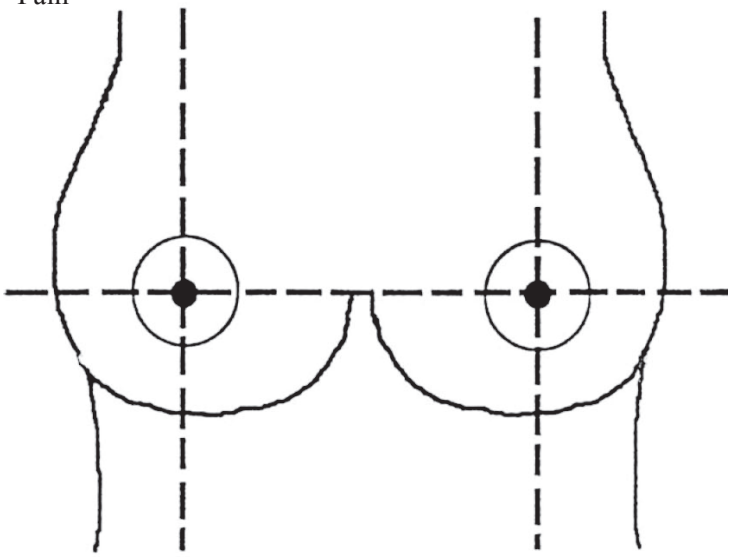
	Right	Left
Routine Screening	☐	☐
Mass or Lump	☐	☐
Nipples Inverted	☐	☐
Axillary Masses	☐	☐
Discharge	☐	☐

Overall Impressions / Comments:

Key: +++ = Scars ● = Lumps ○ = Moles Δ = Pain

Indicate:

1. Scars or moles: ☐ No ☐ Yes
2. Where BB's and scar markers are placed
3. Whether biopsy was positive or negative



By signing this the technologist acknowledges that they have reviewed this information with the patient.

X_____ _____ ____/____/____ __ __ __ __
Technologist Signature Print Name Date Time (24 hour)