AQ Modern Diagnostic Imaging

Name: _____ Birthdate: ___/____/_____

Age: _____ Referring Physician: _____

1. Have you had a prior Mammogram? ----------YES NO
   IF YES, When? _____ Where? _____
2. Do you have any CURRENT breast symptoms (Lumps, pain, nipple discharge)?
   ----------YES NO
   IF YES, please describe symptom, location, and duration:
   _____
   _____
   _____
3. Have you ever had breast cancer before? ---------- YES NO
   IF YES, which breast? LEFT RIGHT When? _____
   What treatments did you receive: MASTECTOMY LUMPECTOMY
   RADIATION HORMONE THERAPY CHEMOTHERAPY
4. Have you ever had any of the following:

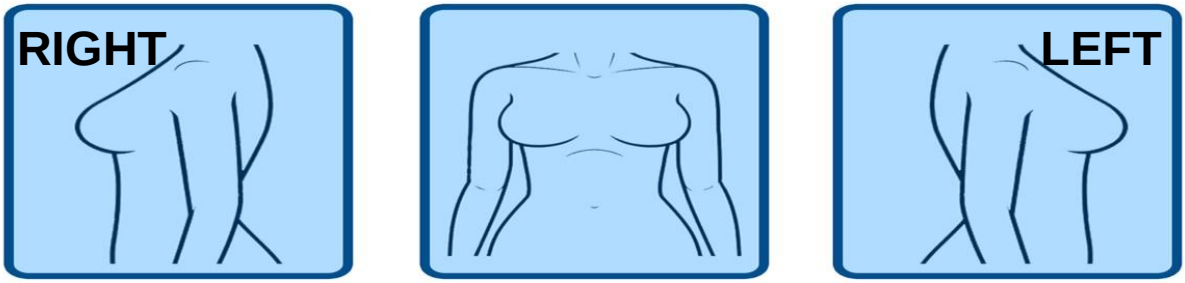
Breast cyst aspiration	YES	NO	if yes, which breast	LEFT	RIGHT
Benign or negative breast biopsy	YES	NO	if yes, which breast	LEFT	RIGHT
Breast implants	YES	NO			
Breast reduction	YES	NO			

5. Do you have family history for breast cancer? ---------- YES NO
   If yes, which relatives and what age were they diagnosed?
   Relation: _____ Age: _____
   Relation: _____ Age: _____
   Relation: _____ Age: _____
6. Are you currently pregnant? ---------- YES NO
   When was your last menstrual period? _____
7. Are you currently breast feeding? ---------- YES NO
8. When did your DR. Last examine your breast? _____

X_____ _____
Patient Signature Date

Technologist's Comments: _____
_____
_____

Radiological Findings:



Tech Name: _____ Date: _____