AQ Modern
Diagnostic Imaging
Premier Radiology Services
315 Elmora Ave Elizabeth, NJ 07208 - Phone: (908) 469-2888 Fax: (908) 469-2882

Breast Ultrasound – History

Name: _____ Date of Birth: _____

Referring Physician: _____

Have you had a prior Mammogram? ---------- YES NO

If yes, When: _____ Where: _____

Have you had a prior breast ultrasound? ---------- YES NO

If yes, when: _____ Where: _____

1. Do you have any current breast symptoms (lump, pain, nipple discharge)?
   ---------- YES NO

   If yes, please describe symptoms, location and duration:

_____

_____

2. Have you had breast cancer in the past? ---------- YES NO
   If yes, which breast LEFT RIGHT When? _____
   What treatments did you receive? Mastectomy lumpectomy
   (***please circle***) hormone therapy radiation chemotherapy
3. Do you have family history of breast cancer? ---------- YES NO
   If yes, which relative and what age were they?
   Relation: _____ Age: _____
   Relation: _____ Age: _____
   Relation: _____ Age: _____
4. When did your DR last examine your breast? _____

X_____ _____
Patient signature Date

Technologist notes:

_____

_____

Tech name: _____ Date: _____