



# Mammography, Breast US and Breast MRI Questionnaire

REFERRING MD \_\_\_\_\_

PRIMARY CARE MD \_\_\_\_\_

NAME \_\_\_\_\_

AGE \_\_\_\_\_

DATE \_\_\_\_\_

DOB \_\_\_\_\_

LAST MENSTRUAL PERIOD \_\_\_\_\_

DATE OF LAST FULL BREAST PHYSICAL EXAMINATION BY A DOCTOR: \_\_\_\_\_

Female patients: Are you currently pregnant? Y / N

### Reason for Mammogram / Breast US / Breast MRI

Routine

Abnormal Mammogram / US

When did symptoms first occur?

Lump (new or enlarging) R / L \_\_\_\_\_

Nipple discharge R / L \_\_\_\_\_

Pain / soreness R / L \_\_\_\_\_

Other R / L \_\_\_\_\_

### History

Have you breastfed within the past six months? Yes No

Have you ever been told you have breast cancer? Yes No

Are you currently on hormone therapy (estrogen)? Yes No

Breast cancer pre-op staging R L

Breast cancer follow-up R L

Is there a history of breast cancer in your family? Yes No

If "Yes" please check / enter age of relative who had cancer:

Sister \_\_\_\_\_  Mother \_\_\_\_\_

Daughter \_\_\_\_\_

### Previous mammograms, breast ultrasounds, or breast MRIs

Most recent \_\_\_\_\_ Where \_\_\_\_\_

Next most recent \_\_\_\_\_ Where \_\_\_\_\_

What exam \_\_\_\_\_

What exam \_\_\_\_\_

### Breast Surgery:

Date

Mastectomy R / L \_\_\_\_\_

Lumpectomy for cancer R / L \_\_\_\_\_

Benign surgical biopsy R / L \_\_\_\_\_

Stereotactic biopsy R / L \_\_\_\_\_

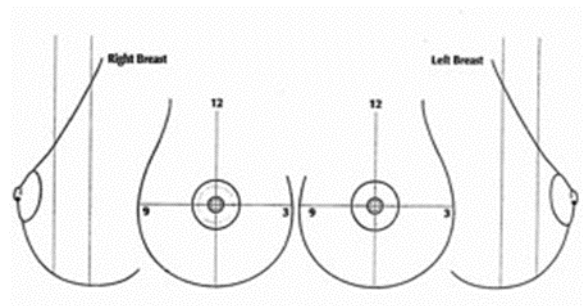
US core biopsy R / L \_\_\_\_\_

Cyst aspiration R / L \_\_\_\_\_

Implants R / L \_\_\_\_\_

Reduction R / L \_\_\_\_\_

MRI Core Biopsy R / L \_\_\_\_\_



Name of Tech: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

# WORKSHEET

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ DATE: \_\_\_\_\_

PROCEDURE: \_\_\_\_\_ SITE \_\_\_\_\_

CLINICAL HISTORY: \_\_\_\_\_

IMPRESSION: \_\_\_\_\_

**\*\*\*\*\*STAFF USE ONLY\*\*\*\*\***

TIME OUT performed \_\_\_\_\_ AM PM Allergies Confirmed YES NO

Procedure \_\_\_\_\_ Site R / L \_\_\_\_\_ Tech/RN Signature \_\_\_\_\_

Radiologist \_\_\_\_\_

eGFR \_\_\_\_\_ Creatinine \_\_\_\_\_ Reference Range \_\_\_\_\_ - \_\_\_\_\_ Date \_\_\_\_\_

Contrast/Amt \_\_\_\_\_ mL Lot# \_\_\_\_\_ Exp Date \_\_\_\_\_ NDC# \_\_\_\_\_ S / M Disc \_\_\_\_\_ mL

Injection Site R / L \_\_\_\_\_ Time \_\_\_\_\_ Flow Rate \_\_\_\_\_ IV device \_\_\_\_\_

Gadavist + Amt \_\_\_\_\_ mL Lot# \_\_\_\_\_ Exp Date \_\_\_\_\_ NDC# \_\_\_\_\_ S / M Disc \_\_\_\_\_ mL

Lidocaine 1%/Xylocaine 1% + Amt \_\_\_\_\_ mL Lot# \_\_\_\_\_ Exp Date \_\_\_\_\_ NDC# \_\_\_\_\_ S / M Disc \_\_\_\_\_ mL

Xylocaine 1% w/Epi 1:100,000 + Amt \_\_\_\_\_ mL Lot# \_\_\_\_\_ Exp Date \_\_\_\_\_ NDC# \_\_\_\_\_ S / M Disc \_\_\_\_\_ mL

Sodium Chloride 0.9% + Amt \_\_\_\_\_ mL Lot# \_\_\_\_\_ Exp Date \_\_\_\_\_ NDC# \_\_\_\_\_ S / M Disc \_\_\_\_\_ mL

Priors: NO YES \_\_\_\_\_

Tech/RN notes? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



Lifetime Risk Assessment (National Cancer Institute) <http://www.cancer.gov/bcrisktool/>

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Please Circle the Correct Answer**

- 1) Do you have a medical history of any breast cancer or of ductal carcinoma in situ (DCIS) or lobular carcinoma in situ (LCIS) or have received previous radiation therapy to the chest for treatment of Hodgkin's Lymphoma?

Yes

No

- 2) Do you have a mutation in either the BRCA1 or BRCA2 gene, or a diagnosis of a genetic syndrome that may be associated with elevated risk of breast cancer? Yes No

- 3) What is your age? \_\_\_\_\_

- 4) What was your age at the time of your first menstrual period?

Unknown

7 - 11

12 - 13

> =14

- 5) What was your age at the time of your first live birth of a child?

Unknown

No births

< 20

20 - 24

25 - 29

>30

- 6) How many of your first-degree relatives - mother, sisters, daughters - have had breast cancer?

Unknown

0

1

More than 1

- 7) Have you ever had a breast biopsy?

Unknown

No

Yes

- 7a) How many breast biopsies (positive or negative) have you had? 1 More than 1

- 7b) Have you had at least one breast biopsy with atypical hyperplasia?

Unknown

Yes

No

- 8) What is your race/ethnicity?

Asian/Pacific Islander

White

American Indian

African American

Alaskan Native

Hispanic

Unknown

Evaluacion de viesgo de por vida (Instituto Nacional de Cancer)

Nombre: \_\_\_\_\_ Fecha de nacimiento: \_\_\_\_\_

Por favor circule la respuesta correcta

1. Tiene usted historia medica de algun tipo de cancer mamario, carcinoma ductal in situ (DCIS) o cancer lobular in situ (LCIS) Ha recibido terapia de radiacion al pecho para el tratamiento de linfoma Hodgkin?

Si

No

2. Tiene usted algun mutacion genetica gene BRCA1 o BRCA2 o ha sido diagnosticada con un syndrome genetico que aumente el riesgo de cancer del seno

Si

No

3. Cuantos anos tiene? \_\_\_\_\_

4. Edad de su primera menstruacion?

No me acuerdo

7 - 11

12 - 13

> =14

5. Edad de su primer embarazo?

No me acuerdo

menor de 20

20-24

25-29

mayor de 30.

6. Cuantos parientes de primer grado \_\_\_\_\_ Mama \_\_\_\_\_ hermanas \_\_\_\_\_ hijas \_\_\_\_\_ han sido diagnosticadas con cancer del seno.

7. Le han hecho alguna biopsia en los senos?

No se

No

Si

- 7A. Cuantas biopsias (positivas o negativas) le han hecho?

1

mas de 1

- 7B. Ha tenido alguna biopsia con resultados de Hiperplasia atipica?

No se

No

Si

8. Cual es su Raza u Origen etnico.

Caucasico

Afroamericano

Hispano

Oriental

Indio Americano Nativo de Alaska

No se



### OUT-PATIENT FALL RISK ASSESSMENT

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SITE NAME: \_\_\_\_\_

INTERVIEWER NAME: \_\_\_\_\_ CUSTOMER NUMBER: \_\_\_\_\_

**Patient:** The following questions are intended to identify patients who may be at risk of falling and to help avoid potential injury. This procedure has been implemented to ensure your safety and to enable us to provide you with the best possible patient care.

Please circle the appropriate answer to each question below. Our staff will go over these questions with you prior to your examination to address any questions or concerns you may have.

1. Have you fallen recently (within the last 3 months)?	YES	NO
2. Do you use a cane, walker or other device to help you walk?	YES	NO
3. Do you require assistance to stand up?	YES	NO
4. Have you taken any medications today for anxiety or to relax you?	YES	NO
If yes, what medication? _____ Dosage _____ Time _____		
5. Are you dizzy, lightheaded, weak in your legs or unable to see or hear clearly?	YES	NO

**Team Member:** If the patient, patient’s family member or caregiver answers “yes” to any of the above questions, transport the patient via wheelchair to the imaging system or exam/treatment room.

All patients must be assessed for falls risk prior to transporting patients from the waiting area. The entire form must be completed signed and retained in the patient’s medical record whenever a patient refuses a wheelchair.

**Mobile Units Only-** The top portion of this document must be completed and retained in the patient’s medical record whenever a mobile units lift or roll/slide door is inoperable and the units stairs must be utilized. If any “yes” answers are provided, the patient may not utilize the mobile unit stairs and must reschedule for a time when the lift/roll/slide door is operable.

#### RELEASE OF LIABILITY

Notwithstanding the evaluated risk of fall and Alliance’s offer/recommendation to use a wheelchair for transport to/from the imaging system or exam/treatment room, I decline the use of a wheelchair. By declining the use of wheelchair for transport to/from the imaging system or exam/treatment room, I agree, acknowledge and assume all inherent risk including but not limited to the risk of falling, personal injury, damage to personal property, or otherwise. I, on behalf of myself, heirs and/or representatives, do hereby waive and agree to release and hold harmless Alliance HealthCare Services, Inc., its officers, agents, subsidiaries and employees from any and all liability for any damage, claim or injury to myself or my property or otherwise.

PATIENT SIGNATURE: \_\_\_\_\_

WITNESS SIGNATURE: \_\_\_\_\_ TITLE: \_\_\_\_\_