ULTRASOUND BREAST QUESTIONNAIRE

Name: _____ DOB: _____ Age: _____

Referring MD: _____Date: _____ Ethnicity: _____

Have you had a mammogram before? Yes_____ No_____

Where and when: _____

Reason for today's exam (circle all that apply): Routine; lump; pain; discharge; follow up

Date of last Clinical breast exam (physical exam by MD) _____ by whom_____

Is there any history of breast cancer in yourself or family? Yes_____ No_____

If so, Whom? _____ At what age? _____

Are you pregnant? _____ Have you breast fed in past 3 months? _____

Have you had a child?_____ Your age at first child's birth_____

Your age at first menses_____ Your age at menopause_____

Do you take hormones such as Estrogen, Premarin, Provera, Birth Control, Synthroid, Tamoxifen? Yes_____ No_____ Which type? _____Duration? _____

Have you gained or lost weight in the past year? _____ How much? _____lbs

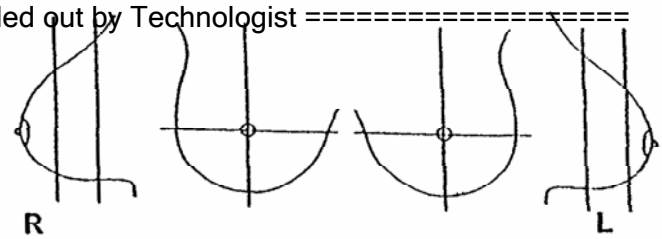
History of prior breast surgery, aspiration, biopsy, implants, reduction? Yes ____ No___

Describe_____ When_____ Where_____

Any radiation to the chest before age 30 (Hodgkin's or non-Hodgkin's lymphoma)? Yes__ No__

========== Below to be filled out by Technologist ==========

Nipples inverted? How long? _____
Breast size difference? _____
o mole; Δ lump/mass; - - scar; ≈ pain



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_____

_____

Technologist Initials _____

Call Back Authorization

It is sometimes necessary for a patient to be called back for additional imaging (extra mammo view/ultrasound). This does not necessarily mean a problem has been detected, but that additional images are necessary to complete the exam. If we cannot reach you by phone directly, do we have your permission to leave a message on your answering machine regarding the needed call back?

Yes_____ No_____

Phone number (home/cell etc)_____
Under current HIPAA regulations, we are not allowed to leave a detailed message unless we have your permission.

Signature_____ Date_____

Medical Release Authorization

MD IMAGING
14 Raymond Avenue Poughkeepsie NY 12603
Tel: 845-471-2848 Fax: 845-471-2919

Medical Records Release:
To:_____
_____
_____

I hereby authorize you to release to MD Imaging any information, including but not limited to, records, films, diagnosis and reports during the past _____ months/years.

_____ _____
Signature Date

_____
Print Name