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JUNEAU, AK 99801
PHONE 907-796-8900
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Bartlett Regional Hospital

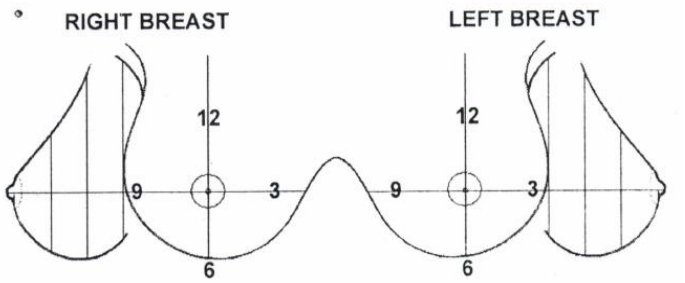
Breast Ultrasound Patient Questionnaire

Date: _____ (PLEASE ANSWER ALL QUESTIONS AND UPDATE ANY NEW INFORMATION)

Name:	MRN:	DOB:
Address:		
Home Phone:	Work Phone	Referring Physician:	Exam Date:

REASON FOR EXAM: PLEASE DESCRIBE ANY PROLEMS YOU ARE HAVING WITH YOUR BREASTS: _____

PREVIOUS EXAMS: IS THIS YOUR FIRST BREAST ULTRASOUND? YES ◯ NO ◯ IF NO, WHEN AND WHERE HAVE YOU HAD A BREAST ULTRASOUND? _____



PLEASE INDICATE ANY AREAS OF PAIN, LUMP, NIPPLE DISCHARGE OR OTHER AREAS OF CONCERN ON THE DIAGRAM ABOVE

FAMILY HISTORY

HAS ANY BLOOD RELATIVE HAD BREAST CANCER? YES ◯ NO ◯ IF YES, PLEASE LIST EACH & THEIR RELATIONSHIP TO YOU:

HAS ANY BLOOD RELATIVE HAD ANY OTHER TYPE OF CANCER? YES ◯ NO ◯ IF YES, PLEASE LIST EACH & THEIR RELATIONSHIP TO YOU:

MEDICAL HISTORY

NUMBER OF PREGNANICIES: _____ DATE OF LAST PERIOD: _____ ARE YOU CURRENTLY BREASTFEEDING: _____

NUMBER OF DELIVERIES: _____ AGE AT FIRST PERIOD: _____ AGE AT HYSTERECTOMY AND/OR OVARIES REMOVED IF ANY: _____

AGE AT FIRST DELIVERY: _____ AGE AT MENOPAUSE: _____

BIRTH CONTROL/HORMONE USE

TYPE: _____ AGE AT FIRST USE: _____ NUMER OF MONTHS OF USE: _____

PERSONAL HISTORY

HAVE YOU HAD BREAST CANCER? _____

IF YES PLEASE DESCRIBE: _____

HAVE YOU HAD OTHER CANCER? _____

IF YES PLEASE DESCRIBE: _____

PLEASE INDICATE THE DATE AND SIDE OF EACH OF THE FOLLOWING: MASTECTOMY, LUMPECTOMY, BIOPSY, RADIATION THERAPY, BREAST RECONSTRUCTION, BREAST IMPLANTS AND BREAST REDUCTION:

PROCEDURE:	SIDE	DATE	PROCEDURE:	SIDE	DATE
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

SIGNATURE

I ATTEST THAT THE INFORMATION I HAVE PROVIDED ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE

_____ _____

SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO CONSENT FOR PATIENT	DATE	TECHONOLOGIST