Santa Barbara Women's Imaging Breast Questionnaire

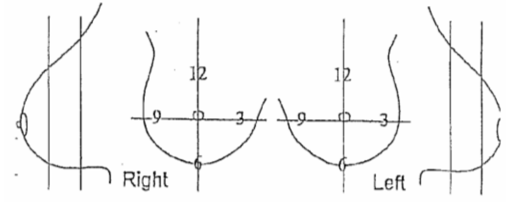
Patient Name:	**MRN:**	**Date of Birth:**	**Age:**
Address:	**City:**	**State:**	**Zip:**
Telephone:	**Cell Number:**	**Preferred #:** ◻ Home ◻ Cell	
Referring Physician:			

Do you currently have a breast problem? Yes / No

(Circle all that apply and mark location on diagram.)

Lump Discharge Change in shape

Pain Other: ______________________



When was your last mammogram and/or ultrasound done?

Mo/Yr ___________ Facility ____________

When was your last breast exam *with your doctor?* Mo/Yr ________ By whom? ____________

Have you ever have been diagnosed with breast cancer? Yes / No

If yes: When were you diagnosed? _____________ ◻ Right ◻ Left

How were you treated? ◻ Lumpectomy ◻ Mastectomy ◻ Radiation

◻ Chemotherapy ◻ Tamoxifen, aromatase inhibitor (For how many years? _____)

Do you have a personal history of any **other** type of cancer? Type _____________ When?_____

Have you had a previous breast procedure? Yes / No (circle all that apply)

Needle Biopsy	◻ Right ◻ Left	Year_______	Pathology (if known) ________________
Surgical Biopsy	◻ Right ◻ Left	Year_______	Pathology (if known) ________________
Breast Reduction		Year_______	
Implants	◻ Saline ◻ Silicone	Year_______	Implant revisions (if any) _______

Hormonal status Date of last period________ Are you **currently** taking hormones? Yes / No

Have you ever taken hormones? Yes / No How long? ___

What type? ◻ estrogen ◻ progestin-estrogen ◻ bio-identical ◻ other: ______________

When did you have your first period? Age: _______

When did you have your first child? Age: _______ How many children do you have? _______

Do you have a family history of breast or ovarian cancer? **Family history of other cancer?**

	Yes / No	**Age when diagnosed?**	**Type of cancer?**
Mother	___ / ___	____________________	_______________________
Sister	___ / ___	____________________	_______________________
Daughter	___ / ___	____________________	_______________________
Other	___ / ___	____________________	_______________________

What is your ethnicity? (This is used for assessment of breast cancer risk) Other ___________

Caucasian ____ African American ____ Hispanic ____ Asian ____ Ashkenazi Jewish ____

Have you or any member of your family ever been tested for BRCA mutation?

◻ No If yes, who? ___________________ Result? ◻ Positive ◻ Negative

Did you have radiation to the chest (e.g. for lymphoma) before the age of 30?

◻ No If yes, reason? ____

Signature: ____ **Date:**