HEADWATERS
Health Care Centre

Breast Biopsy Intake Form

Patient Information

Name: ______________________ Phone Number: ______________________

HCN: ______________________ Birth Date: ______________________

Date: ______________________ MRN: ______________________

Completed By: ______________________

Appointment Information

Appointment Date: ______________________ Account Number: ______________________

Biopsy Modality: ______________________

Family Physician (physician/NP who signed authorization form) ______________________

Requesting Radiologist: ______________________

Surgeon Assigned: ______________________

Reason for Examination

☐ Abnormal screening mammogram

☐ Symptomatic (select all that apply)

☐ Right Breast ☐ Left Breast

☐ Lump ☐ Nipple Inversion

☐ Skin Thickening ☐ Breast Pain

☐ Nipple Discharge ☐ Other:

Have you had a previous mammogram? ☐ Yes ☐ No Most recent date: ______________________

Have you had a previous ultrasound? ☐ Yes ☐ No Most recent date: ______________________

If yes, did you have your mammogram/ultrasound at Headwaters? ☐ Yes ☐ No

If not, where did you have your most recent mammogram/ultrasound done? ______________________

Do you have a **personal** history of breast disease? ☐ Yes ☐ No

If yes, please provide details:

____

____

Have you ever had a previous breast biopsy or needle aspiration? ☐ Yes ☐ No

☐ Right Side ☐ Left Side

Date: ______________________ Result: ______________________

Have you ever had any breast surgery? ☐ Yes ☐ No

☐ Reduction ☐ Augmentation/Implants

☐ Right Side ☐ Left Side ☐ Both

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Do you have a **family** history of: ☐ Breast Cancer ☐ Ovarian Cancer ☐ Endometrial Cancer

☐ Yes ☐ No

If yes, please select who and the age of cancer onset:

Maternal	Comment	Paternal	Comment
☐ Mother		☐ Aunt (Maternal)	
☐ Sister		☐ Aunt (Paternal)	
☐ Grandmother (Maternal)		☐ Cousin (Maternal)	
☐ Grandmother (Paternal)		☐ Cousin (Paternal)	

What age did you begin your menstrual cycle? ______________________________

Are you currently pregnant or is there a chance that you could be pregnant? ☐ Yes ☐ No

Have you had any full-term pregnancies? ☐ Yes ☐ No

If yes, how many? ____________ How old were you when you delivered your children? ____________

Did you breast feed your children? ☐ Yes ☐ No If yes, for how long did you breast feed? __________

Are you still having regular menstrual cycles? ☐ Yes ☐ No

Have you gone through menopause? ☐ Yes ☐ No If yes, at what age did you start? __________

Have you ever used hormone replacement therapy? ☐ Yes ☐ No

If yes, what type did you use? ______________________________ If yes, for how long? __________

Have you been diagnosed with any medical condition(s) that required treatment? ☐ Yes ☐ No

If yes, list below:

____

____

____

Have you ever had any previous surgery or operations? ☐ Yes ☐ No

If yes, list below:

____

____

____

Do you take any medications or supplements? ☐ Yes ☐ No

If yes, list below:

____

____

____

Do you take any blood thinning medications including: ☐ Yes ☐ No

☐ ASA	☐ Brillinta	☐ Clopidogrel	☐ Coumadin	☐ Eliquis
☐ Garlic	☐ Gingko Bilboa	☐ Heparin	☐ Lixiana	☐ Pradaxa
☐ St. John's Wart	☐ Turmeric	☐ Xarelto	☐ Other:	

Do you have any allergies?	☐ Yes	☐ No	
Do you smoke?	☐ Yes	☐ No	If yes, how many per day?
Do you drink any alcohol?	☐ Yes	☐ No	If yes, how many drinks per week?