

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:

Prior to Current Medical Concerns

Have you had a previous mammogram? No Yes Date: _____
 Have you had a previous ultrasound? No Yes Date: _____
 If yes, did you have your mammogram/ultrasound at Headwaters? No Yes
 If not, where did you have your most recent mammogram/ultrasound done? _____
 Do you have a **personal** history of breast disease? No Yes - If yes, please provide details below

Have you ever had a previous breast biopsy or needle aspiration? No Yes - If yes, please provide details below

Right Side Left Side

Date: _____ Result: _____

IF YES SELECTED ABOVE FOR ANY QUESTION WITHIN THIS SECTION, PLEASE PROVIDE REPORTS (IF AVAILABLE).

Have you ever had any breast surgery? No Yes - If yes, please provide details below

Reduction Augmentation/Implants

Right Side Left Side Both



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	Age	Comment	Paternal	Age	Comment
<input type="checkbox"/> Mother			<input type="checkbox"/> Aunt (Maternal)		
<input type="checkbox"/> Sister			<input type="checkbox"/> Aunt (Paternal)		
<input type="checkbox"/> Grandmother (Maternal)			<input type="checkbox"/> Cousin (Maternal)		
<input type="checkbox"/> Grandmother (Paternal)			<input type="checkbox"/> 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

- | | | | | |
|--|--|--------------------------------------|-----------------------------------|----------------------------------|
| <input type="checkbox"/> ASA | <input type="checkbox"/> Brillinta | <input type="checkbox"/> Clopidogrel | <input type="checkbox"/> Coumadin | <input type="checkbox"/> Eliquis |
| <input type="checkbox"/> Garlic | <input type="checkbox"/> Gingko Bilboa | <input type="checkbox"/> Heparin | <input type="checkbox"/> Lixiana | <input type="checkbox"/> Pradaxa |
| <input type="checkbox"/> St. John's Wart | <input type="checkbox"/> Turmeric | <input type="checkbox"/> Xarelto | <input type="checkbox"/> 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?

