NYMI
NEW YORK MEDICAL IMAGING ASSOCIATES
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BREAST IMAGING QUESTIONNAIRE

PATIENT NAME:_____ **DOB:** _____ **AGE:**_____

Phone number(s): Home:_____ Work:_____Cell:_____

1. Have you had a mammogram performed within the last 5 years? ☐**Yes** ☐ **No**
   ☐**Here** ☐**Elsewhere?**_____

2. **Have you ever had breast surgery?** ☐**Yes** ☐ **No** If so,
   ☐**BIOPSY** ☐**ASPIRATION** ☐**MASTECTOMY** ☐**LUMPECTOMY** ☐**RADIOTHERAPY** ☐**IMPLANTS** ☐**REDUCTION**
   Which Breast(s)?: ☐**Right** ☐ **Left** ☐ **Both** When?:_____
   Results: ☐Benign: _____ ☐ Malignant: _____

3. **Current breast problems?** ☐**Yes** ☐ **No**
   ☐**Lump**_____ ☐**Right** ☐ **Left** ☐ **Both**
   ☐**Discharge** _____ ☐**Right** ☐ **Left** ☐ **Both**
   ☐Other: _____

4. **Family History of Breast Cancer** ☐ None If yes, please indicate age diagnosed
   Mother_____ **Father** _____ **Daughter**_____ **Sister**_____
   Aunt (maternal/paternal) _____ **Grandmother** (maternal/paternal) _____
   First cousin (maternal/paternal) _____

5. **Physical breast exam by your physician within last 12 months?** ☐**Yes** ☐ **No**

6. **Name of your referring physician (s):**
   #1 _____
   #2_____ #3 _____

TECHNOLOGIST'S NOTES:

Pregnancy Waiver

I, the undersigned fully understand the x-ray procedure. I understand that if I am pregnant at this time radiation may be harmful to the fetus.

Patient Signature:_____**Date:**_____