Beth Israel Lahey Health
Beth Israel Deaconess Needham

148 Chestnut Street
Needham, MA 02492

PATIENT'S NAME ____________

MED. REC. # ____________

DOB ____________

Patient Identification

MR1927

INTEGRATED BREAST CARE CENTER PATIENT QUESTIONNAIRE

Date: ____/____/____

Best daytime number: ( ) _________ - ____________ Alternate number: ( ) _________ - ____________

Referring Clinician: ____

Reason for Today's Exam: ☐ Routine ☐ Other: ____________________________

Previous Mammograms: ☐ No ☐ Yes When: ____/____/____ Where: ____________________

Previous Breast MRI: ☐ No ☐ Yes When: ____/____/____ Where: ____________________

Have you had a recent breast exam by your clinician? ☐ No ☐ Yes Findings: ____________________

Have you had weight gain or loss since last mammogram? ☐ No ☐ Yes Amount gained / lost: ____________

Previous Breast Surgery: ☐ No ☐ Yes ***If Yes***, continue answering:

	Right	Left	When:	Result:
Breast Biopsy	☐	☐	____/____/____	____________
Breast Aspiration	☐	☐	____/____/____	____________
Mastectomy / Lumpectomy for cancer	☐	☐	____/____/____	____________
Radiation Therapy	☐	☐	____/____/____	____________
Breast Implants	☐	☐	____/____/____	____________
Other Breast Surgery	☐	☐	____/____/____	____________

Medical History:

Age Menstruation Began: ____________ Last Period: ____/____/____ Age at Menopause: ____________

Are you a known breast cancer mutation carrier? ☐ No ☐ Yes ☐ Unknown – not tested

Have you ever been pregnant? ☐ No ☐ Yes ***If Yes,*** Age at first full-term pregnancy: ________

Number of Pregnancies: ________ Number of Children: ________

Hysterectomy? ☐ No ☐ Yes When: ____/____/____

Ovaries removed? ☐ No ☐ Yes When: ____/____/____

Birth Control Pills? ☐ No ☐ Now ☐ Previously: Age at start? ____ Length Time / Years: ____

Fertility medication? ☐ No ☐ Now ☐ Previously: Age at start? ____ Length Time / Years: ____

Post-menopausal hormone replacement? ☐ No ☐ Now
☐ Previously: Age at start? ____ Length Time / Years: ____

Tamoxifen? ☐ No ☐ Now ☐ Previously: Age at start? ____ Length Time / Years: ____

Cancer History:

Does anyone in your family have a history of:	No	Yes	Personal History	Relative	Mother / Father side	Age of diagnosis
Breast cancer	☐	☐	☐			
Ovarian cancer	☐	☐	☐			
Other cancer: ____________	☐	☐	☐			
Other cancer: ____________	☐	☐	☐			

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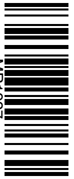
Patient Identification



Date: ____/____/____

Optional Question: ***We ask because this information helps determine your risk of breast cancer more accurately**

What is your race / ethnicity? ☐ African American ☐ Alaskan Native ☐ American Indian ☐ Asian American ☐ Hispanic ☐ White ☐ Unknown

X____________________ Patient's Signature ____________________ Print Name **OR**

X____________________ Signature of Person authorized to sign for patient ____________________ Print Name **and** ____________________ Relationship to patient

Date: ____/____/____ **Time:** __ __ : __ __ ○ a.m. ○ p.m.

DO NOT WRITE BELOW THIS LINE – FOR TECHNOLOGIST USE ONLY

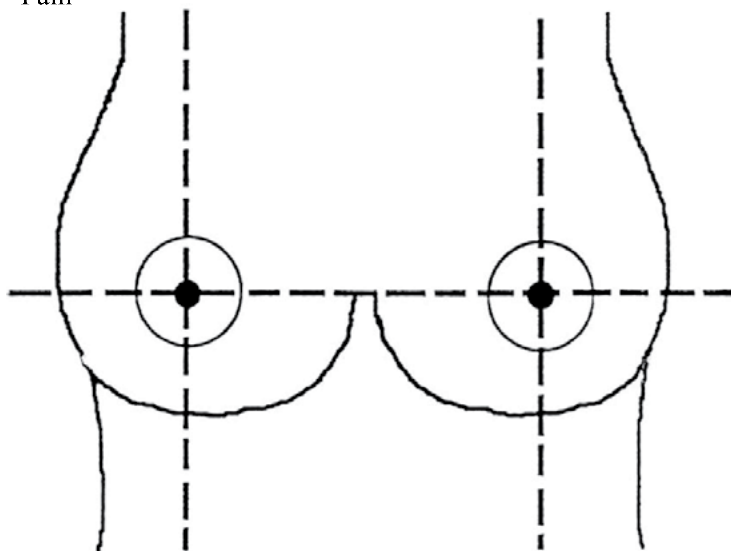
	Right	Left
Routine Screening	☐	☐
Mass or Lump	☐	☐
Nipples Inverted	☐	☐
Axillary Masses	☐	☐
Discharge	☐	☐

Overall Impressions / Comments:

Key: +++ = Scars ● = Lumps ○ = Moles Δ = Pain

Indicate:

1. Scars or moles: ☐ No ☐ Yes
2. Where BB's and scar markers are placed
3. Whether biopsy was positive or negative



By signing this the technologist acknowledges that they have reviewed this information with the patient.

X____________________ Technologist Signature ____________________ Print Name ____/____/____ Date __ __ __ __ Time (24 hour)