Crystal Run Healthcare

95 Crystal Run Road
Middletown, NY 10941
845-703-6999

61 Emerald Place
Rock Hill, NY 12775
845-794-6999

855 Route 17M
Monroe, NY
845-615-6999

1200 Route 300
Newburgh, NY
845-725-0100

81 Ronald Reagan Blvd.
Warwick, NY
845-986-5123

Breast questionnaire (Please inform technologist if you are wearing any powder or deodorant)

Name: ______________________________ Date: ______________________________

Date of Birth: ______________ Age: ______ Referring MD? ______________________

Height: ______________ Weight: ________

Reason for today's exam: ________________________________(Routine, lump, follow up, other)

Date of last clinical breast exam done by your doctor? ______________________

Are you pregnant? Yes No If no, date of last period: ___ #of childbirth deliveries:________

Have you breast fed in the last 3 months? Yes No Age at first pregnancy: ______________

Have you ever had a mammogram? Yes No If yes, when and where? ______________

________________________________Your age at first menstrual period: ________

Have you gone through menopause? Yes No Don't Know If yes, Age: ________

Have you ever been diagnosed with ovarian cancer? Yes No

Do you or a family member have a history of breast cancer? Yes No

If yes, whom and what age?____

Do you have a mutation in either BRCA1 or BRCA2 gene? Unknown Tested, Normal

BRCA1+ BRCA2+

Ashkenazi Inheritance? Yes No

Do you currently use hormone replacement therapy (HRT) such as BCP, Estrogen, Premarin, Provera, Tamoxifen, or Synthroid? Never Stopped use 5 or more years ago Stopped use less than 5 years ago Current user If yes, which type? ______________________________

Have you ever had breast surgery, cyst aspirations, biopsies, implants, or reductions? Yes No

If yes, please describe type of surgery: ______________________________________

When and where did surgery take place? ______________________________________

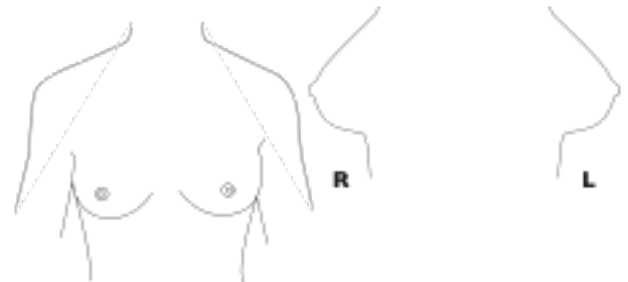
Patient Name: ______________________ Patient Signature: ______________________

Technologist portion

Inverted nipples? Yes No

Breast size difference? Yes No

If yes, how long? ______________________



Comments/reason for additional views:

____

Tech: ______________________________

Mole ● Lump △ Scar △△

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Medical Release Authorization if not done at Crystal Run Healthcare

I hereby authorize ____

(Name of facility where last mammogram was done)

to release any information pertaining to Mammograms or breast ultrasounds, including but not limited to, records, images (CD preferred), diagnosis and reports from the past __________ months/year to:

Crystal Run Healthcare *61 Emerald Place* *Rock Hill, NY 12775* *P. 845.796.5472 F. 845.796.5493*	OR	*Crystal Run Healthcare* *155 Crystal Run Road* *Middletown, NY 10941* *P. 845.703.6182. F. 845.703.2023*

Patient

Patient Name (print):____

Patient Signature:____

Date of Birth:_________________________ Date: ___________________________

Prior mammogram return (Please check preference)

After comparison of prior mammogram, CRHC should:

Return to facility   Return to patient   Keep in CRHC file

Call back authorization

It is sometimes necessary for a patient to be called back for additional imaging (extra mammo views and/or breast ultrasound studies). This does not necessarily mean that a problem has been detected, but that additional images are needed to complete the exam.

If we cannot reach you by phone directly, do we have your permission to leave a message on your answering machine regarding the needed call back? Under current HIPAA regulations, we are not allowed to leave a detailed message unless we have your permission.   Yes   No

Home number: ____________________________________

Cell number:_____________________________________

Patient

Patient Signature:____

Date: ____