Princeton Radiology
Excellence in Imaging

Screening Mammography Questionnaire

Name:_____ D.O.B.___/___/___ Sex: M / F MRN: _____

SCREENING MAMMOGRAM:

☐ I have no breast related symptoms or complaints

☐ I have a specific concern _____

Please note, if you have a specific concern such as a lump or focal and non-cyclical pain, you may need to obtain a referral for a diagnostic mammogram and reschedule your exam.

GENERAL HISTORY:

☐ YES NO ☐ Is there any chance you may be pregnant? Date of last menstrual period?_____

☐ YES NO ☐ Have you breast fed within the last 6 months?

☐ YES NO ☐ Are you taking any type of hormones? If yes, how long?_____

☐ YES NO ☐ Do you have breast implants? If yes, type: ☐ Silicone ☐ Saline

☐ YES NO ☐ Any prior imaging? Where/when? _____

☐ YES NO ☐ Prior surgery or biopsy:

Side: ☐ right / ☐ left / ☐ both sides

Result: ☐ benign ☐ malignant ☐ atypia_____

*When:*_____

☐ YES NO ☐ Do you have a personal history of breast cancer?

Side: ☐ right / ☐ left / ☐ both sides

Type: _____

Age: _____

☐ YES NO ☐ Radiation treatments to your breast? ☐ R / ☐ L *When?* _____

☐ YES NO ☐ Chemotherapy? *When?* _____

☐ YES NO ☐ Hormonal therapy? *When?* _____

☐ YES NO ☐ Do you smoke currently or have you ever smoked?

If YES, for how many years? _____years

How many packs per day? _____ packs per day

How long ago did you quit? If still smoking, mark as "0": _____ years ago

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I acknowledge that all the information given is accurate and thereby consent to have a Mammography examination performed on me.

Signature:_____ Date:___/___/___

Technologist Notes: _____

_____

Technologist Initials: _____

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Breast Cancer Risk Questionnaire

Name:________________________________ D.O.B.___/___/___ Age:_______

List relatives who have a history of breast or ovarian cancer & their age of onset below:

1° Relatives	2° Relatives Mother's Side	2° Relatives Father's Side
Parents, Siblings, Children	***Grandparents, Aunts, Nieces, Half-siblings***	***Grandparents, Aunts, Nieces, Half-siblings***
Age of Onset: ☐ Breast ________ ☐ Ovarian ________ (Relative)	Age of Onset: ☐ Breast ________ ☐ Ovarian ________ (Relative)	Age of Onset: ☐ Breast ________ ☐ Ovarian ________ (Relative)
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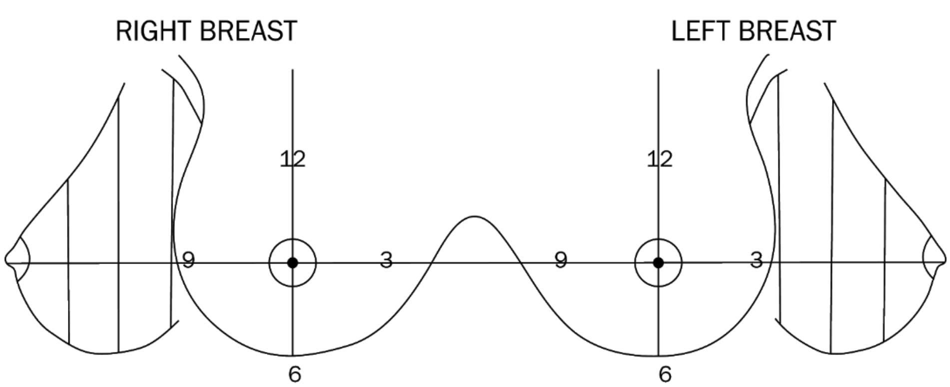
☐ YES NO ☐ Have you been tested for the BRCA gene? Result? ☐ Positive / ☐ Negative
☐ YES NO ☐ Does one of your 1° Relatives have the BRCA gene? (if unknown, check no)
☐ YES NO ☐ Did you have radiation therapy to the chest between 10 and 30 years of age?
☐ YES NO ☐ Do you have a personal history of breast cancer? Age at diagnosis:_____________
☐ YES NO ☐ Is your family history unknown? (for example, if you were adopted, check yes).

DO NOT WRITE BELOW THIS LINE --- FOR TECHNOLOGIST USE



☐ YES NO ☐ Clause Score > 20 Claus Score: _______ Prior Density: ______

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In Office Screening Radiology Exam Visit During COVID Patient Authorization and Consent Form

During the COVID-19 pandemic, there is some increased risk for people who visit a healthcare provider. Health problems can happen from being exposed to:

- other patients
- healthcare staff
- healthcare facilities

Some people have a higher risk of complications from COVID-19, including those with:

- asthma
- chronic lung disease
- serious heart disease or problems
- chronic kidney disease
- extreme obesity
- a compromised or suppressed immune system
- liver disease
- pregnant
- age 65 or older
- nursing home or long-term care facility residents

If these people at high-risk get COVID-19, they may have a greater chance for having more health problems. These may be serious, and could result in the need for hospitalization and even death.

Other Evaluation Choices

Although Princeton Radiology has taken many steps to ensure your safety, screening exams are non-urgent. You could:

- postpone the exam to a later date or
- discuss the need for the exam further with your doctor.

These other options may or may not be right for you. This depends on your situation and overall health. Some screening radiology exams do screen for cancer and therefore risk factors may play a role for you in this decision.

More Facts

Medical and office staff may help when you arrive and while you are evaluated and treated. They will follow state laws and recommendations from local, state, and national health officials related to caring for patients during the COVID-19 pandemic. However, they cannot eliminate risks, especially for high-risk patients.

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Consent to Treatment

The first page of this consent form told you about COVID-related risks. If, after reviewing this form, you do not believe that you really understand the risks and choices, **do not sign the form until all questions have been answered.**

_____I understand the facts provided to me on the first page of this consent form. I give my consent for in-office screening radiology examination. By signing below, I agree that staff has discussed the facts in this form with me, that no one has given me any guarantee, that I have had a chance to ask questions, and that all of my questions have been answered.

_____ _____
Signature of Patient or Responsible Party Date and Time

_____
Relationship to Patient (if Responsible Party is not Patient)

_____ _____
Witness Date and Time