affidea

MR – breast examination questionnaire
Date of examination:

Please fill out with printed capital letters.

Name: Mothers' name:

Date of birth: SSN:

Additional examination questionnaire for performing breast MR examination

— Dear Patients,

Please answer the questions below, marking your answer with an X using the check box.

When was a breast ultrasound examination done before?

☐ Year ☐ Month ☐ There was no

When was a breast MR done before?

☐ Year ☐ Month ☐ There was no

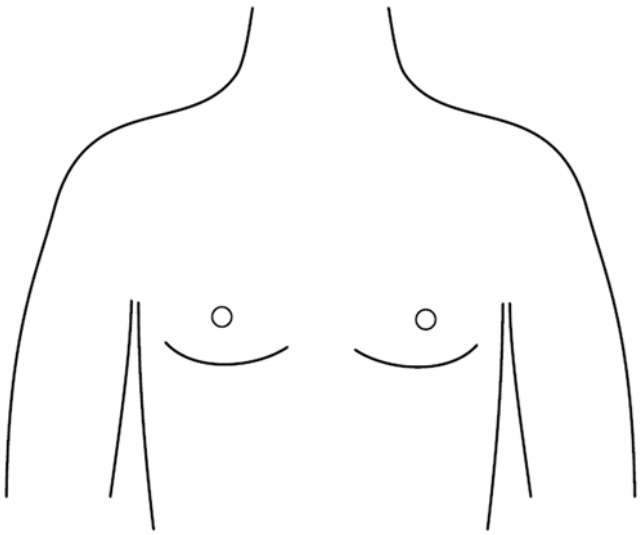
Have you had breast surgery?
☐ Yes, because of a benign tumor
☐ Yes, because of a malignant tumor
☐ Yes, for cosmetic reason
☐ No

Have you had radiation therapy?
☐ Yes ☐ No

Did you ever have a core needle biopsy (of the breasts)?
☐ Yes ☐ No

Have you had a breast biopsy?
☐ Yes, with benign result
☐ Yes, with malicious result
☐ Yes, with uncertain result
☐ Yes, with uninformative result
☐ No

TO BE COMPLETED BY HEALTHCARE PERSONNEL



— Are you currently having any of the following problems?

Lump in the breast?	☐ On the left side	☐ On the right side	☐ There is no lump
Nipple retraction?	☐ On the left side	☐ On the right side	☐ There is no nipple retraction
Any kind of skin lesion on the breast?	☐ On the left side	☐ On the right side	☐ There is no skin lesion
Pain in the breast?	☐ On the left side	☐ On the right side	☐ There is no pain
Nipple discharge?	☐ On the left side	☐ On the right side	☐ There is no nipple discharge
Colour of nipple discharge?	☐ Bloody	☐ Yellowish	☐ Other

Please fill out with printed capital letters.

Name: Mothers' name:

Other current breast problems:

Family history

Is there a family history of breast/ovary cancer?

☐ Parent ☐ Grandparent ☐ Sibling ☐ No, there is not

Medical history

Have you had breast inflammation?

☐ Yes ☐ No

Have you had trauma/injury to the breast?

☐ Yes ☐ No

Do you receive hormone replacement therapy?

☐ Yes, for 1-3 months
☐ Yes, for 6 months
☐ Yes, for 1 year
☐ Yes, for 2 years
☐ Yes, for 2-5 years
☐ Yes, for 5-10 years
☐ Yes, for over 10 years

Other information

☐ I am currently taking part in an IVF treatment
☐ I have thyroid disease
☐ I have diabetes
☐ I have a haematopoietic disease
☐ I have take oral contraceptives (birth control pills)
☐ No

Date of last menstruation

Year Month

Signature of the patient (or legal representative)