Inland Empire
Imaging Center

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Patient Questionnaire- Breast

1. Name: ____________________________________ Date: _____/______/______
2. Date of birth: ___/___/____ Height: ___________ Weight: _____
3. Are you currently taking any medications? ( ) Yes ( ) No

   If yes, what type of medication: ____

   ____

   ____

4. Do you have breast pain? ( ) Yes ( ) No ( ) Left side ( ) Right side

   ( ) Both sides

   If yes, how long have you had this pain? ___________________________

5. Do you feel any lumps in either breast? ( ) Yes ( ) No

   If yes, how long has it been there? _______________________________

6. Have you had an ultrasound done before? ( ) Yes ( ) No

   If yes, when and where? ____

7. Have you been diagnosed with cancer? ( ) Yes ( ) No

   If yes, what kind? ____

8. Do you have a family history of cancer? ( ) Yes ( ) No
9. Is there anything you would like to disclose to the sonographer before the procedure? __

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Patient Signature: _________________________________Date: ____/____/____