Crystal Run Healthcare

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

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

Radiology Questionnaire

Breast questionnaire [Please inform technologist if you are wearing any powder or deodorant]

Name: _____ Date of Birth: _____

Date: _____ Age: _____ Day phone #: _____

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 Your age of 1st full term pregnancy ____

Have you ever had a hysterectomy? ☐ Yes ☐ No If yes, full or partial? _____

Have you ever had a mammogram? ☐ Yes ☐ No

If yes, when and where? _____

Referring MD? _____

History of breast cancer in you or your family? ☐ Yes ☐ No

If yes, whom and what age?_____

Do you currently take hormones such as BCP, Estrogen, Premarin, Provera, Tamoxifen, or Synthroid? ☐ Yes ☐ No

If yes, which type?_____ For how long? _____

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

If yes, please describe: _____

When and where surgery took place: _____

Patient: _____ Patient Signature

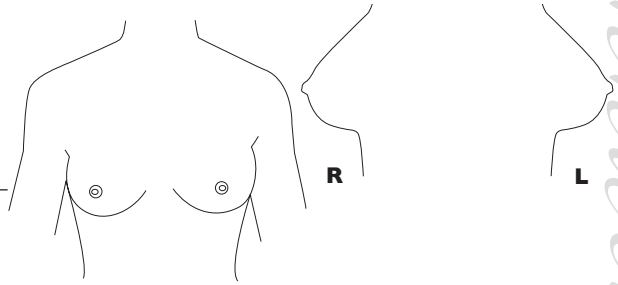
[Patient- continued on back]

Technologist portion

Inverted nipples? ☐ Yes ☐ No

Breast size difference? ☐ Yes ☐ No

If yes, how long? _____



Comments/reason for additional views:

_____

Tech _____ Mole ● Lump △ ScarΔΔ

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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
95 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

Medical Release