HEADWATERS Health Care Centre

Breast Biopsy Intake Form

Patient Information

Name: _____ Birth Date: _____

HCN: _____ MRN: _____

Date: _____ Completed By: _____

Appointment Information

Appointment Date: _____ Account Number: _____

Biopsy Modality: _____ Requesting Radiologist: _____

Reason for Examination

☐ Abnormal screening mammogram

☐ Symptomatic (select all that apply) Date(s) of onset: _____

☐ Right Breast ☐Left Breast

☐ Lump ☐ Skin Thickening ☐ Nipple Discharge ☐ Nipple Inversion ☐ Breast Pain

Are you currently pregnant or is there a chance that you could be pregnant? ☐ Yes ☐ No

Have you had a previous mammogram? ☐ Yes ☐ No Most recent date: _____

Have you had a previous ultrasound? ☐ Yes ☐ No Most recent date:_____

If yes, did you have your mammogram/ultrasound at Headwaters? ☐ Yes ☐ No

If not, where did you have your most recent mammogram/ultrasound done? _____

Do you have a **personal** history of breast disease? ☐ Yes ☐ No If yes, please provide details:

_____

_____

Have you ever had a previous breast biopsy or needle aspiration? ☐ Yes ☐ No

☐ Right Side ☐ Left Side

Date: _____ Result: _____

Have you ever had any breast surgery? ☐ Yes ☐ No

☐ Reduction ☐ Augmentation/ Implants

☐ Right Side ☐ Left Side ☐ Both

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Do you have a **family** history of: ☐ Breast Cancer ☐ Ovarian Cancer ☐ Endometrial Cancer
If yes, please select who and the age of cancer onset:

Maternal	Comment	Paternal	Comment
☐ Mother		☐ Aunt (Maternal)	
☐ Sister		☐ Aunt (Paternal)	
☐ Grandmother (Maternal)		☐ Cousin (Maternal)	
☐ Grandmother (Paternal)		☐ Cousin (Paternal)	

What age did you begin your menstrual Cycle? _____

Have you had any full-term pregnancies? ☐ Yes ☐ No

If yes, how many? _____ How old were you when you delivered your children? _____

Did you breast feed your children? ☐Yes ☐No If yes, for how long did you breast feed? _____

Are you still having regular menstrual cycles? ☐ Yes ☐ No

Have you gone through menopause? ☐ Yes ☐ No If yes, at what age did you start? _____

Have you ever used hormone replacement therapy? ☐ Yes ☐ No

If yes, what type did you use? _____ If yes, for how long? _____

Have you been diagnosed with any medical condition(s) that required treatment? ☐ Yes ☐No If yes, please list below:

_____

_____

_____

Have you ever had any previous surgery or operations? ☐ Yes ☐No If yes, please list below:

_____

_____

_____

Do you take any medications or supplements? ☐ Yes ☐ No If yes, please list below:

_____

_____

_____

Do you take any blood thinning medications including:

☐ ASA ☐ Brillinta ☐ Clopidigrel ☐ Coumadin ☐ Eliquis
☐ Garlic ☐ Gingko Bilboa ☐ Heparin ☐ Lixiana ☐ Pradaxa
☐ St. John's Wart ☐ Turmeric ☐ Xarelto ☐ Other:

Do you have any allergies?	☐ Yes	☐ No	
Do you smoke?	☐ Yes	☐ No	If yes, how many per day?
Do you drink any alcohol?	☐ Yes	☐ No	If yes, how many drinks per week?