

patientquestionnaire for MR-Mammography

Surname: _____ First name: _____

Birth date: _____ Date of Examination: _____

Dear Ms _____,

You are going to receive an MR-Mammography.

We will explain the entire procedure to you prior to the examination and we will answer all your questions concerning the examination in a personal interview. In the aid of accurate evaluation and interpretation of the examination results, it is necessary for you to provide some information, e.g. regarding pre-examinations or any prior breast diseases. We would therefore request that you answer the following questions as accurately as possibly.

1. Under which telephone numbers can we reach you?	In the evening:	During the day:
2. When was your last mammography x-ray carried out?	Month:	Year:
3. Where was it carried out?		
4. Have you ever had an MR mammography carried out on you?	YES <input type="checkbox"/>	No <input type="checkbox"/>
5. For which reason should an MR Mammography be carried out now?	For preventive/precautionary reasons <input type="checkbox"/> Inconclusive findings in your previous mammography <input type="checkbox"/> Inconclusive findings in the ultrasound examination <input type="checkbox"/> Findings by palpitation <input type="checkbox"/> For how long have the findings by palpitation been known? <hr/> Secretion (discharge of fluid from nipple) Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral <input type="checkbox"/>	
6. Have you already received operations to the breast?	Yes <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral <input type="checkbox"/>	No <input type="checkbox"/>
7. Operation outcome?	Benign <input type="checkbox"/> Malign <input type="checkbox"/> Unknown <input type="checkbox"/>	
8. Have your breast(s) been radiated already?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
9. Until which date was the radiation carried out?		

10. Do you still get your period?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, when was the first day of your last period?		
11. Do you take regular medication?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, which medication?		
12. Do you take hormones or apply a hormone patch?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
if yes, since when and which type?		
13. Has anyone in your family ever contracted breast cancer?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, what is the degree of relationship and at what age was the illness diagnosed?		
14. Has anyone in your family ever contracted ovarian cancer?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, what is the degree of relationship and at what age was the illness diagnosed?		