

2007 Fox Chase Cancer Center Mobile Mammography Program

HEALTH HISTORY QUESTIONNAIRE CR

Screening Criteria – PLEASE REVIEW CAREFULLY -

A woman is **not eligible** for a screening mammogram on the van if any of the following apply:

- She is under the age of 40 (please see *For AETNA & IBC Members)
- She has implants
- She has had a breast cancer diagnosis within the past two years
- She is currently being treated for breast cancer
- She has a new breast problem (such as a palpable lump, skin changes or nipple discharge)
- She does not provide a prescription from her physician
- She does not provide the name and address of at least one physician
- She does not bring her previous mammography films for comparison purposes
- She is breast feeding or has breast fed within the last nine months

*FOR AETNA MEMBERS - One baseline mammography between the ages of 35 TO 39

*FOR IBC MEMBERS - Starting at age 35, Independence Blue Cross allows yearly mammograms

**A SIGNED PRESCRIPTION FROM YOUR PHYSICIAN FOR A SCREENING MAMMOGRAM IS REQUIRED
(A FAXED COPY IS ACCEPTABLE).**

PARTICIPANT INFORMATION

Name _____ SS# _____
 Last First MI Date of Birth ____ / ____ / ____
 Address _____
 Street _____
 City State Zip Code Employer: _____
 Telephone - Home _____ Work _____ Cell _____
 E-Mail Address _____

EMERGENCY CONTACT - Name _____ Relationship _____
 Address _____
 Street City State Zip
 Telephone - Home _____ Work _____ Cell _____

Physician Information: You must provide the name, address, telephone and fax number of at least one physician to whom your results will be sent. Without this information, we will be unable to perform a screening mammogram on the Fox Chase Cancer Center Mobile Mammography Van. **A FAX NUMBER WILL ALLOW US TO NOTIFY YOUR PHYSICIAN WITHIN FIVE DAYS OF TESTING.**

MANDATORY			OPTIONAL		
Physician's Name			Name		
_____	_____	_____	_____	_____	_____
Last	First	Degree (MD/DO)	Last	First	Degree (MD/DO)
Address			Address		
_____			_____		
Street			Street		
_____			_____		
City	State	Zip	City	State	Zip
_____	_____	_____	_____	_____	_____
Telephone	FAX #		Telephone	FAX #	
_____	_____		_____	_____	

Location of Previous Mammogram:

Location/Site _____ Date _____

NAME: _____

DATE: _____

MEDICAL INFORMATION

IS THIS YOUR FIRST MAMMOGRAM?
Yes No

WEIGHT GAIN OR LOSS IN LAST YEAR?
Yes No

RISK FACTORS

NONE PERSONAL HISTORY OF BREAST CANCER? Yes No

PERSONAL HISTORY OF ANY OTHER CANCER? Yes No
TYPE _____

PERSONAL HISTORY OF GYN CANCER? Yes No

FAMILY HISTORY – BREAST CANCER ONLY

NONE AUNT/COUSIN/GRANDMOTHER (WEAK) Yes No

MOTHER/SISTER: POST MENOPAUSAL (INTERMEDIATE) Yes No

MOTHER/SISTER: PRE MENOPAUSAL (STRONG) Yes No

IMPLANTS

Yes No

BREAST REDUCTION

Yes No

HORMONE USAGE

NONE ESTROGEN(PREMARIN)
CURRENTLY?
Yes No
EVER?
Yes No

PROGESTERONE(PROVERA)
CURRENTLY?
Yes No
EVER?
Yes No

TAMOXIFEN
CURRENTLY?
Yes No

RALOXIFENE
CURRENTLY?
Yes No

HISTORY OF PROCEDURES

NONE CYST ASPIRATION
IN LEFT BREAST Yes No
IN RIGHT BREAST Yes No
BILATERALLY Yes No

EXCISIONAL BIOPSY (NOT CANCER)
IN LEFT BREAST Yes No
IN RIGHT BREAST Yes No
BILATERALLY Yes No

MASTECTOMY
IN LEFT BREAST Yes No
IN RIGHT BREAST Yes No
BILATERALLY Yes No

NEEDLE BIOPSY
IN LEFT BREAST Yes No
IN RIGHT BREAST Yes No
BILATERALLY Yes No

LUMPECTOMY (CANCER)
IN LEFT BREAST Yes No
IN RIGHT BREAST Yes No
BILATERALLY Yes No

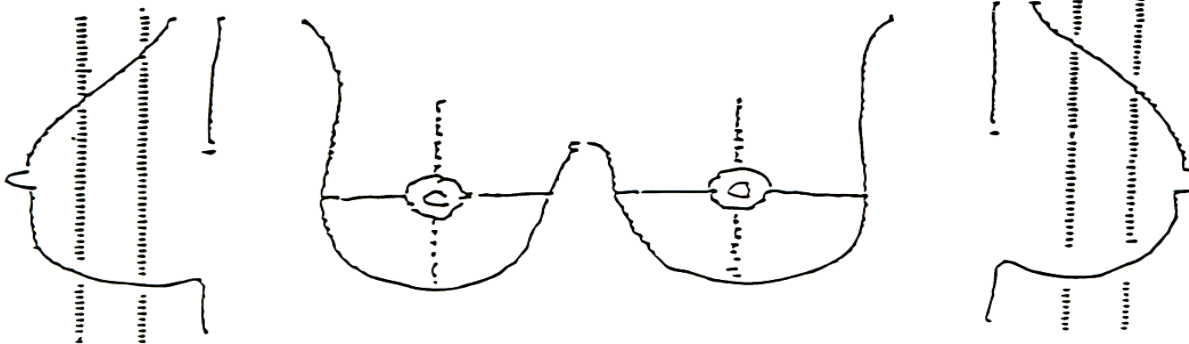
RADIATION THERAPY
IN LEFT BREAST Yes No
IN RIGHT BREAST Yes No
BILATERALLY Yes No

TO THE BEST OF MY KNOWLEDGE, THE INFORMATION I HAVE PROVIDED ON THE FRONT AND BACK OF THIS FORM IS CORRECT:

SIGNATURE: _____

DATE: _____

FOR OFFICE USE ONLY



RIGHT

LEFT

(Initials)

(Date)