Röntgenpraxis im SpreeCenter

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Questionnaire - Breast Diagnostics

Name: **First name:** **Date of Birth:**

Mobile number:

Dear patient,
You have been referred to us for examination of your mammary gland. For an optimal diagnosis, please answer the following questions:

Have you had a lump palpated?	0 Yes	0 No
Where?	0 Right	0 Left
Do you have pain in the breast?	0 Yes	0 No
Where? ________________		
Is the breast secreting any kind of secretion or blood?	0 Yes	0 No
Which side and what?	0 Right	0 Left
Do you have breast implants?	0 Yes	0 No
Have you had any breast surgery or puncture?	0 Yes	0 No
Where and what? ________________		
Have you had breast cancer treatment?	0 Yes	0 No
Have you given birth to children?	0 Yes	0 No
Did you breastfeed for more than 4 weeks?	0 Yes	0 No
Did you have any problems while breastfeeding?	0 Yes	0 No
Which ones? ________________		
When did you have your last menstrual period? ________________		
Do you take the pill or hormones from the gynecologist?	0 Yes	0 No
Which drug? ________________		
Is there a possibility of pregnancy?	0 Yes	0 No
Have you had ovarian cancer or colon cancer?	0 Yes	0 No
Is there a family history of breast cancer?	0 Yes	0 No
Before the age of 50?	0 Yes	0 No
Who?		
Have you had a mammogram?	0 Yes	0 No
When and where? ________________		
Have you been vaccinated against Corona? If so with what? ________________	0 Yes	0 No
Do you have a febrile infection or Corona infection?	0 Yes	0 No
I consent to receive mammography	0 Yes	0 No
I agree with the transmission of information to the referring physician?	0 Yes	0 No

If you do **not** wish to be called by name, please contact the registration desk.

Date: **Signature:** ---------------------------------

We take the protection of your personal data very seriously and adhere to the Data Protection Regulation (DSVO), which is displayed in the waiting room for your information.