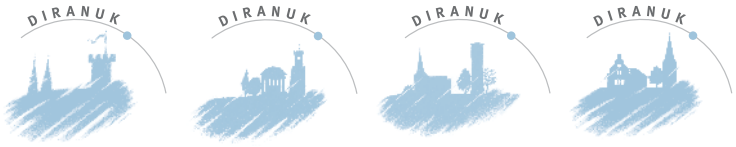
Patientenetikett



MVZ DIRANUK GmbH – Bielefeld | Bad Salzuflen | Gütersloh | Bünde

CASE HISTORY QUESTIONNAIRE MAMMOGRAPHY/MAMMA SONOGRAPHY

Dear patient, please answer the following questions:

Surname, first name, date of birth

_____

Details about previous breast examinations

Have you had an **ultrasound scan (sonographic examination)** before? ☐ Yes ☐ No

If yes, please state when and where. _____

Have you had a **mammography** before? ☐ Yes ☐ No

If yes, please state when and where. _____

Have you undergone **breast magnetic resonance imaging (MRI)**? ☐ Yes ☐ No

If yes, please state when and where. _____

Are we permitted to request the findings for comparison? ☐ Yes ☐ No

Details about previous breast operations

Have your **breasts** been **operated** on? ☐ Yes ☐ No

If yes, please tick the relevant answer:

- ☐ Was a tissue biopsy taken? ☐ Left ☐ Right When? _____
- ☐ Was a benign tumour removed? ☐ Left ☐ Right When? _____
- ☐ Have you had breast-conserving surgery? ☐ Left ☐ Right When? _____
- ☐ Did you have a mastectomy? ☐ Left ☐ Right When? _____
- ☐ Did you have a breast enlargement/reduction? ☐ Left ☐ Right When? _____

Have you previously been diagnosed with **"breast cancer"**? ☐ Yes ☐ No

If yes, please state when (date of diagnosis): _____

Treatment details

Did you undergo **radio-therapy** for your breast(s)? ☐ Left ☐ Right When? _____

☐ Yes ☐ No Where? _____

Did you undergo **anti-hormonal** therapy? When? _____

☐ Yes ☐ No If yes, ☐ is still running ☐ is finished Preparation: _____

Did you undergo **chemo therapy**? When? _____

☐ Yes ☐ No If yes, was it ☐ before or ☐ after the Operation? Where? _____

Symptoms

Do you suffer from any breast pain/symptoms? ☐ Left ☐ Right ☐ Yes ☐ No

If yes, please describe the pain/symptoms: _____

Have you noticed any discharge from your nipples? ☐ Yes ☐ No

☐ Left ☐ Right ☐ Bloody ☐ Not bloody Colour: _____

Information on medication

☐ Hormone Tablet or Hormone Patch ☐ No ☐ No

Do any of your family members suffer from breast cancer "B" or ovarian cancer "O". If so, please indicate either "B" or "O".

Who has contracted cancer? _____ Age of onset: _____

Additional information

Last day of your last menstruation: _____

☐ I herewith confirm that to my knowledge, I am currently not pregnant. I am aware that X-rays can harm an unborn child.

You are entitled to a copy of this medical history questionnaire. (Under Section 630 e, sub-section 2, sentence 2, BGB)

☐ I do not require a copy of this medical history questionnaire. ☐ I would like a copy of this medical history questionnaire.

_____ _____

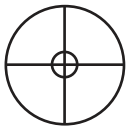
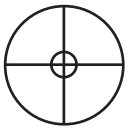
Place, Date Signature Patient

0402 – 3.2022

Thank you for your help!

This page will be completed by the clinician!

Untersuchungsbefund

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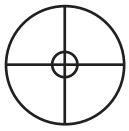
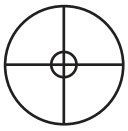
Tastbefund:

BW 1	weich	mittel	fest
BW 2	weich	mittel	fest
BW 3	weich	mittel	fest

Kalk:

Sonografie

Vorbefund:

Standard-Aufnahmen

R-cc

L-cc

R-mlo

L-mlo

Zusatz-Aufnahmen