PATIENT SCREENING QUESTIONNAIRE FOR STEREOTACTIC BREAST BIOPSIES

Patient's name _____
Age _____
Weight _____
Phone # _____

Referring MD _____
Referring MD's phone number _____

Medications

Currently taking _____

_____

_____

Arthritis or pain medications (Aspirin, Ibuprofen, Aleve, Naprin, Advil or Motrin, Celebrex, Vioxx, etc.) _____

Currently on any blood thinners (Aspirin, Coumadin, Heparin, Plavix, etc.) _____

_____

Does the patient suffer from asthma? Yes_____ No_____
If yes, please bring nasal or mouth spray to the procedure.

Has the patient undergone any chemotherapy in the last 3 mos? Yes_____ No_____

Can the patient be prone for more than 25 minutes? Yes_____ No_____

Does the patient have any significant shoulder, back, or neck pain? Yes_____ No_____

Does the patient have any allergies? Yes_____ No_____
If yes, to what _____

_____

Has the patient breast fed for the last 3 months or is currently breast feeding?
Yes_____ No_____

Does the patient suffer from high blood pressure? Yes_____ No_____
If yes, does the patient take medication? Yes_____ No_____
If yes, is it usually controlled with it? Yes_____ No_____

Comments _____

_____

_____

Filled out by: _____