Breast Health Center
Pre Procedure Questionnaire

Patient Name ___________________________ DOB ____________

(Please complete this form to assist your radiologist)

Height ________  Weight ________

Check the side of your body the procedure is being performed

☐ Left  ☐ Right

Are you on anticoagulants, aspirin or aspirin like compounds (i.e. Advil)?  ☐ Yes  ☐ No

If yes, name of medication ___________________________  Last dose ____________

List All drugs and foods you are Allergic or Sensitive to and how they affect you.  ☐ NONE

☐ Lidocaine  ☐ Latex  ☐ Tape

<table>
<thead>
<tr>
<th>Allergies/Sensitivities</th>
<th>Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Swelling</td>
<td>☐ Wheezing</td>
</tr>
<tr>
<td>☐ Other</td>
<td>☐ Itching</td>
</tr>
<tr>
<td>☐ Other</td>
<td>☐ Nausea</td>
</tr>
</tbody>
</table>

Check any medical problems you have  ☐ NONE

☐ high blood pressure  ☐ diabetes  ☐ blood clotting  ☐ breathing
☐ heart arrhythmia  ☐ thyroid  ☐ seizures  ☐ asthma
☐ heart disease  ☐ kidney  ☐ liver/hepatitis  ☐ stroke
☐ other

List All medications, vitamins, and herbal products you take (including insulin)  ☐ NONE


Patient Signature ___________________________ Date/Time ____________

If you are not the patient, what is your relationship? ___________________________