PIH HEALTH

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Breast Health Center
Pre Procedure Questionnaire

ACT: MR:
DOB:
ADM: RM:

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

Allergies/Sensitivities	Reaction
	☐ Swelling ☐ Wheezing ☐ Itching ☐ Nausea ☐ Other _____
	☐ Swelling ☐ Wheezing ☐ Itching ☐ Nausea ☐ Other _____
	☐ Swelling ☐ Wheezing ☐ Itching ☐ Nausea ☐ Other _____

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? _____