Mammogram/Mammasono-Patient Questionnaire

DIAGNOSTIKUM BERLIN by Evidia Group

PLEASE FILL OUT THIS FORM AND MARK THE RELEVANT INFORMATION:

Last name: **First name:** **Birthdate:**

Tel: **My last mammography was:**

Email:

Are there any older images of the examination area? Yes (Diagnostikum) ○ Yes (other provider) ○ no ○ will be given later ○

Do you have a breast implant? yes ○ no ○

If yes, which side? right ☐ left ☐

If yes, since when?

Do you have any complaints or discomfort in the examination area? yes ○ no ○

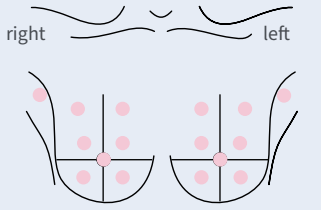
If yes, which?

☐ Palpable nodules ☐ Pain

☐ Pulling ☐ Skin changes/Redness

☐ Retraction ☐ Breast enlargement

☐ Fluid leakage Please mark the points of discomfort. →



Have you ever had an illness or surgery related to the breast? yes ○ no ○

If yes, when? ☐ benign ☐ malignant Which side? left ☐ right ☐

How were you treated? ☐ Chemotherapy ☐ Hormone therapy ☐ Radiation therapy ☐ OP ☐ Ablatio

Have you ever had surgery on your lower abdomen? yes ○ no ○

If yes, when?

Which kind of operation?

I am currently taking hormones (menopausal). yes ○ no ○

If yes, which? Since when?

FAMILY MEDICAL HISTORY

In my family, breast cancer has occurred: yes ○ no ○

☐ Daughter ☐ Mother ☐ Sister ☐ Grandmother ☐ Aunt/Cousin Age of onset:

In my family, ovarian cancer has occurred: yes ○ no ○

☐ Daughter ☐ Mother ☐ Sister ☐ Grandmother ☐ Aunt/Cousin Age of onset:

PERSONAL MEDICAL HISTORY

Number of childbirths: **Are you pregnant?** yes ○ no ○

My last period was on: **I have been in menopause since:**

Other remarks:

turn over please →

☐ **My referring doctor shall receive the results of the examination.**

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Consent Declaration

By my signature, I confirm (if applicable, on behalf of the patient):

- that I have read and understood the information sheet and have answered the questions regarding the medical history (patient history) to the best of my knowledge.
- that I have been thoroughly informed about the planned examination. I have no further questions and feel fully informed.
- that I have carefully considered my decision. I do not require any further reflection period and consent to the examination.

Doctolib

○ I hereby consent to being reminded of my appointment by Diagnostikum Berlin. By giving my consent, I agree to the processing of my ☐ mobile phone number or ☐ email address for the purpose of appointment reminders. Please note that we use Doctolib as a service provider for sending appointment reminders. This consent is given on the basis of Article 9(2)(a) in conjunction with Article 6(1)(a) and Article 7 of the GDPR.

My personal data will not be processed or transmitted for any other purposes.

○ I do **not** consent to the appointment reminder service.

I hereby consent to the examination and confirm that all the information provided here is truthful and complete. I may revoke my consent to the transmission of data to my referring physician and to the appointment reminder service at any time without providing reasons. A revocation pursuant to Article 7(3) of the GDPR does not invalidate the legal basis for data processing carried out in the past. It only takes effect for the future from the moment the revocation is received.

I agree that I will NOT receive a copy of the informed consent form. yes ○ no ○

Date, Patient signature/Authorized Representative X

Name Authorized Representative

TO BE FILLED OUT BY MEDICAL PERSONNEL

Last name: **First name:** **Birth date:**

Anatomische Besonderheiten:

Anmerkungen der MTR, die nicht zu anatomischen Besonderheiten gehören: **Name MTR:**

☐ Kreislaufschwäche

Bemerkungen des Arztes zur Bildqualität:

(z.B. warum sind aufnahmen nicht wiederholt worden?)