

QTscan Patient Medical History Form

Welcome to the Couri Center for Gynecology and Integrative Women's Health. We are glad that you have chosen us for your QTscan. Thank you for placing your trust in us for your care. We are committed to providing exceptional service and maintaining the highest standards of excellence in all that we do.

QT scanning offers advanced imaging technology designed to deliver precise, high-resolution images without radiation exposure, making it a safe and effective tool for state of the art breast imaging. We are proud to offer this innovative service to support your health journey. Please take a moment to fill out the questions below. Thank you.

Personal Information:

Full Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

Email Address: _____

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

Reason for Visit:

- Reason for breast imaging: _____
 - Symptoms or concerns (if any): _____
 - Date of last breast imaging (if applicable): _____
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Breast Health History:

Phone: (309) 692-6838

Fax: (309) 691-6858

Website: www.couricenter.com

- Have you ever had a mammogram, ultrasound, or MRI of the breast? Yes No
 - If yes, when and where? _____
 - Have you ever had a QTscan? Yes No
 - Do you have a **personal** history of ovarian cancer? Yes No If yes, when: _____
 - Do you have a family history of ovarian cancer? Yes No
 - If yes, please list relationship(s) and age at diagnosis: _____
 - Do you have a **personal** history of breast cancer? Yes No If yes, when: _____
 - Do you have a family history of breast cancer? Yes No
 - If yes, please list relationship(s) and age at diagnosis: _____
 - Please list any surgeries you've had related to your breasts: _____
 - Have you ever had a mastectomy? No Right Left
 - Have you ever had a lumpectomy? No Right Left
 - Have you ever had a breast biopsy? No Yes
 - If yes, when and what were the results? _____
 - Have you had any radiation therapy to the chest? If yes, specify: _____
 - Are you currently experiencing any of the following:
 - Breast pain
 - Lump or thickening
 - Skin changes on the breast
 - Nipple discharge
 - Cyst aspiration
 - Other: _____
 - Do you have breast implants? Yes No
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Medical History:

- Do you have a history of:
 - Hormonal therapy (e.g., birth control, HRT)? If yes, specify: _____
 - Other medical conditions (e.g., autoimmune disorders): _____
 - Have you ever had genetic testing? Yes No
 - If so, when was it done and what were the results? _____
 - If you've never had genetic testing, are you interested in it now? Yes No
 - Do you have any magnetic implants in the chest area (ex: pacemaker, defibrillator)?
 Yes No
 - Are you currently pregnant or breastfeeding? Yes No
 - When was your last menstrual period? _____
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Lifestyle Factors:

- Do you smoke or use tobacco products? Yes No
 - Do you consume alcohol? Yes No
 - If yes, how often? _____
 - Do you have regular breast self-exams? Yes No
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Medications and Allergies:

- Are you currently taking any medications, supplements, or vitamins? Yes No
 - If yes, please list: _____
 - Do you have any known allergies (e.g., medications, latex)? Yes No
 - If yes, please list: _____
 - Are you allergic to chlorine or adhesive? Yes No
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Additional Information:

- Is there anything else we should know about your health or concerns regarding breast imaging? _____
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Acknowledgment:

I acknowledge that the information provided is accurate and complete to the best of my knowledge.

Signature: _____ **Date:** _____