COURI CENTER
for Gynecology and Integrative Women's Health

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): _____

Phone: (309) 692-6838 Fax: (309) 691-6858 Website: www.couricenter.com

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Breast Health History:

- 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? □ Yes □ No
  - 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

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
- Do you follow a specific diet or exercise routine? □ Yes □ No
    - If yes, please describe: _____

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

Additional Information:

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

Acknowledgment:

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

Signature: _____ **Date:** _____