

V. DATA COLLECTION

DATA COLLECTION

To facilitate the collection of data across systems and databases, the American College of Radiology (ACR) and the Breast Cancer Surveillance Consortium (BCSC) have collaboratively developed two data collection forms for use within a mammography practice. Based on a standard set of core variables and a standard definition of screening mammography, data are collected through the use of two data collection forms at the time of the mammographic study. The first data collection form includes information about a woman's personal health history relevant to breast cancer; the second form includes clinical and technical information about the imaging performed.

Standardizing data structure permits comparison with national data that are published by the BCSC. Using a set of standard questions in a standard format affords a facility the opportunity to participate as a site, in states that have a BCSC Registry. The BCSC effort is creating mammography data that are being used to build databases that can be linked with each other and with pathology data on cancer outcomes from population based registries. For more information on the BCSC go to:

<http://breastscreening.cancer.gov/elements.html>.

The ACR seeks to improve the measurement of mammography performance through technical and interpretive practice. Data collection and analysis, whether for internal audit or participation in registry and national database activities, is the responsibility of every practice. The ACR encourages all facilities to participate in quality databases to assess performance. It is through standardized reporting and data exchange that practices can compare their own performance from year to year, and compare their practice to aggregated practice data on a regional and national level. This promises to enhance the practice of screening mammography for all who participate.

Please note that these forms are to assist in data collection for participation in database and registry activities and do not constitute a written mammography report.

Patient Information Form

1. Today's date: ____ / ____ / ____ (mm/dd/yyyy)
2. Date of examination (if different from today's date) ____ / ____ / ____ (mm/dd/yyyy)
3. Name _____
4. Previous last name that may have been used when having a mammogram? _____
5. Address: Street or PO Box _____ Apt. _____
City _____ State _____ Zip Code _____ - ____
Day Time Phone _____ - _____ - _____
6. Date of birth: ____ / ____ / ____ (mm/dd/yyyy)
7. Health care provider: _____
Address: _____

8. What health care coverage is paying for your mammogram? (check all that apply)
- | | |
|--|---|
| <input type="checkbox"/> Medicare | <input type="checkbox"/> Managed Care (HMO, Health Plan, PPO) |
| <input type="checkbox"/> Medicaid (Medi-Cal) | <input type="checkbox"/> Not Sure |
| <input type="checkbox"/> Private Insurance | <input type="checkbox"/> I have no coverage |
| <input type="checkbox"/> Other: _____ | |

Note: This item could have selections specific to the state where the practice is located.

9. Height ____ feet ____ inches 10. Weight ____ pounds
11. Are you of Hispanic or Latino origin? Yes No
12. What is your racial/ethnic identity? (check all that apply)
- | | |
|---|--|
| <input type="checkbox"/> White | <input type="checkbox"/> Native Hawaiian or other Pacific Islander |
| <input type="checkbox"/> Black/African American | <input type="checkbox"/> American Indian or Alaska Native |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Other: _____ |
13. What is the highest level of education you have completed? (check one)
- | | |
|---|---|
| <input type="checkbox"/> Less than high school graduate | <input type="checkbox"/> Some college or technical school |
| <input type="checkbox"/> High school graduate or GED | <input type="checkbox"/> College or post-college graduate |

14. Breast problems or breast changes in the last 3 months? (check "None", or all that apply)
- | | |
|---|--|
| <input type="checkbox"/> None | |
| <input type="checkbox"/> Palpable Lump | <input type="checkbox"/> Both <input type="checkbox"/> Left <input type="checkbox"/> Right |
| <input type="checkbox"/> Nipple discharge | <input type="checkbox"/> Both <input type="checkbox"/> Left <input type="checkbox"/> Right Describe: _____ |
| <input type="checkbox"/> Pain | <input type="checkbox"/> Both <input type="checkbox"/> Left <input type="checkbox"/> Right |
| <input type="checkbox"/> Skin thickening or retraction | <input type="checkbox"/> Both <input type="checkbox"/> Left <input type="checkbox"/> Right |
| <input type="checkbox"/> Large axillary lymph node | <input type="checkbox"/> Both <input type="checkbox"/> Left <input type="checkbox"/> Right |
| <input type="checkbox"/> Breast implant problem | <input type="checkbox"/> Both <input type="checkbox"/> Left <input type="checkbox"/> Right |
| <input type="checkbox"/> Abnormal nipple | <input type="checkbox"/> Both <input type="checkbox"/> Left <input type="checkbox"/> Right |
| <input type="checkbox"/> Presence of other cancer | <input type="checkbox"/> Both <input type="checkbox"/> Left <input type="checkbox"/> Right |
| <input type="checkbox"/> Difficult clinical examination | <input type="checkbox"/> Both <input type="checkbox"/> Left <input type="checkbox"/> Right |
| <input type="checkbox"/> Other | <input type="checkbox"/> Both <input type="checkbox"/> Left <input type="checkbox"/> Right If other, describe: _____ |

15. What is the main reason for your mammogram today? (check one box only and fill in below)
- | |
|--|
| <input type="checkbox"/> Routine screening |
| <input type="checkbox"/> Additional evaluation as follow-up for a recent routine screening exam |
| <input type="checkbox"/> Evaluation of a symptom or a finding at clinical examination |
| <input type="checkbox"/> Follow-up at short interval (less than 9 months) from prior exam |
| <input type="checkbox"/> History of breast augmentation (no current complaints) |
| <input type="checkbox"/> Prior to breast reduction surgery |
| <input type="checkbox"/> Prior to radiation therapy |
| <input type="checkbox"/> Additional evaluation as follow-up for a non-screening exam from another facility |

Describe in your own words: _____

Patient Information Form (continued)

16. When was your last mammogram? Date ___ / ___ / ___ (mm/yyyy)

(If unknown check one below)

- Never had a mammogram before today More than 1 year ago up to 2 years ago
 Within the past 6 months Longer than 2 years ago
 7 months to about 1 year ago Not sure

17. Where did you have your last mammogram?

- At this facility
 At another facility: Name and city of facility _____

18. When did a health care provider last examine your breasts? (check one)

- Never More than 1 year ago
 Within the past 3 months Not sure
 4 months to 1 year ago

19. Have you ever been diagnosed with breast cancer? (check one)

- No
 Yes Both Left Right

If Yes: Year of breast cancer diagnosis: right ___ ___ ___ (yyyy); left ___ ___ ___ (yyyy), or

Age when first diagnosed with breast cancer: right ___ years old; left ___ years old.

20. Have you had any of the following breast procedures? (check "None", or all that apply)

- None
- | | | | | |
|---|-------------------------------|-------------------------------|--------------------------------|--------------------------------|
| <input type="checkbox"/> Fine-needle or cyst aspiration | <input type="checkbox"/> Both | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Date ___ / ___ / ___ (mm/yyyy) |
| <input type="checkbox"/> Core-needle biopsy | <input type="checkbox"/> Both | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Date ___ / ___ / ___ (mm/yyyy) |
| <input type="checkbox"/> Surgical biopsy (benign results) | <input type="checkbox"/> Both | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Date ___ / ___ / ___ (mm/yyyy) |
| <input type="checkbox"/> Biopsy—not sure what type | <input type="checkbox"/> Both | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Date ___ / ___ / ___ (mm/yyyy) |
| <input type="checkbox"/> Lumpectomy for breast cancer | <input type="checkbox"/> Both | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Date ___ / ___ / ___ (mm/yyyy) |
| <input type="checkbox"/> Mastectomy | <input type="checkbox"/> Both | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Date ___ / ___ / ___ (mm/yyyy) |
| <input type="checkbox"/> Breast reconstruction | <input type="checkbox"/> Both | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Date ___ / ___ / ___ (mm/yyyy) |
| <input type="checkbox"/> Radiation therapy | <input type="checkbox"/> Both | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Date ___ / ___ / ___ (mm/yyyy) |
| <input type="checkbox"/> Breast reduction | <input type="checkbox"/> Both | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Date ___ / ___ / ___ (mm/yyyy) |
| <input type="checkbox"/> Breast implants (still present) | <input type="checkbox"/> Both | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Date ___ / ___ / ___ (mm/yyyy) |
| <input type="checkbox"/> Breast implants (been removed) | <input type="checkbox"/> Both | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Date ___ / ___ / ___ (mm/yyyy) |

21. If you have implants currently, what type are they? (check all that apply)

- | | | | |
|---|-------------------------------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Silicone gel | <input type="checkbox"/> Both | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Combination | <input type="checkbox"/> Both | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Saline | <input type="checkbox"/> Both | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Pre-pectoral | <input type="checkbox"/> Both | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Retro-pectoral | <input type="checkbox"/> Both | <input type="checkbox"/> Left | <input type="checkbox"/> Right |

22. Have you ever been treated with chemotherapy? (check one)

- No Yes Not Sure

23. Have any of your close blood relatives been diagnosed with breast cancer?

- Family history unknown
- | | | | | |
|-----------|-----------------------------|------------------------------|------------------------------------|-----------------------------------|
| Mother: | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Not Sure | |
| Sister: | <input type="checkbox"/> No | <input type="checkbox"/> One | <input type="checkbox"/> 2 or more | <input type="checkbox"/> Not Sure |
| Daughter: | <input type="checkbox"/> No | <input type="checkbox"/> One | <input type="checkbox"/> 2 or more | <input type="checkbox"/> Not Sure |

If you answered "Yes", were any of these relatives diagnosed before age 50?

- | | | | | |
|-----------|-----------------------------|------------------------------|------------------------------------|-----------------------------------|
| Mother: | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Not Sure | |
| Sister: | <input type="checkbox"/> No | <input type="checkbox"/> One | <input type="checkbox"/> 2 or more | <input type="checkbox"/> Not Sure |
| Daughter: | <input type="checkbox"/> No | <input type="checkbox"/> One | <input type="checkbox"/> 2 or more | <input type="checkbox"/> Not Sure |

24. Have you or a blood relative ever been diagnosed with ovarian cancer? (check one)

- No Not Sure
 Yes (check all that apply) self mother, sister, or daughter more distant blood relative

25. Have you ever given birth? (check one)

- No Yes If "Yes", how old were you when your first child was born? ___ years old.

At what age did you have your first menstrual period? ___ years old

Patient Information Form (continued)

26. Have your menstrual periods stopped permanently? (check one)

- No
- Not sure
- Yes: age when they stopped: ___ years old

If you answered "No" or "Not sure", when did your last period begin? ___ / ___ / ___ (mm/dd/yyyy)

If you answered "Yes", what is the reason that your periods stopped? (check one)

- Natural menopause
- Surgical procedure
- Chemotherapy
- Other reason

27. Are you currently taking hormone medications? (check "None", or all that apply)

- None
- Contraceptive (birth control) age first use ___ age last use ___ # years used ___
- Hormone replacement age first use ___ age last use ___ # years used ___
 - Estrogen only
 - Progesterone only
 - Estrogen and progesterone
 - Tamoxifen or raloxifene age first use ___ age last use ___ # years used ___
 - Other hormone: age first use ___ age last use ___ # years used ___

Describe: _____

