



Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_

Are you a Self-Referral patient? YES NO

Please tell us the reason for your Mammogram and any additional information regarding your breast history:

\_\_\_\_\_

Have you ever had a Mammogram: YES NO If YES, When was it? \_\_\_\_\_ Where? \_\_\_\_\_

Have you ever had a Breast Ultrasound: YES NO If YES, When was it? \_\_\_\_\_ Where? \_\_\_\_\_

Have you ever had a Breast MRI: YES NO If YES, When was it? \_\_\_\_\_ Where? \_\_\_\_\_

If you had a screening mammogram within one year, your insurance may deny your claim and you will be responsible.

PHYSICAL CONCERNS

Table with columns: PHYSICAL CONCERNS, YES, NO, RIGHT, LEFT, HOW LONG? Rows include: Do you feel a lump?, Focal / Specific point of pain?, Any recent trauma to breast?, Any recent skin change to the breast?, Any nipple discharge? ->Circle one: Bloody or NON-bloody

BREAST SURGICAL HISTORY

Table with columns: BREAST SURGICAL HISTORY, YES, NO, RIGHT, LEFT, MONTH / YEAR Rows include: Previous breast cancer, Mastectomy, Lumpectomy, Radiation therapy, Chemotherapy, Biopsies (needle or surgical), Needle Aspiration, Reconstruction/Reduction, Implants or silicone injections

\*\*If marked yes, please be advised that Implants can be damaged and/or ruptured during a mammogram examination. If you decide to proceed with your mammogram, please initial in the following box ->->->

GENERAL HISTORY

Table with columns: GENERAL HISTORY, YES, NO, YES, NO Rows include: Are you Pregnant?, Breast fed in the last 4-6 months?, Are you taking birth control?, Have you had any other type of cancer?, Family history of Breast cancer?, Are you in Menopause?, Are you taking hormone therapy for menopause?, Have you had a Hysterectomy?, If yes, what kind?, Which relative? At what age?

By signing below, I acknowledge and understand these statements:

I am not pregnant. Accuracy of mammograms overall is about 87% in detecting breast cancers. Some redness/tenderness of my breast may occur following my mammogram for 1-2 days due to compression of my breast from the mammography machine. I might be called back to the office for additional work-up. I am responsible for getting my mammogram results if I have not heard back within 2-3 weeks from my referring doctor. I understand that if I continue to have breast problems, regardless of a negative mammogram report, I will contact my doctor for instructions on further follow-up/treatment. I authorize the release of my breast imaging information, images, and copies pertinent to my medical history and for follow up of any suspicious findings.

Patient Signature: \_\_\_\_\_

Today's Date: \_\_\_\_\_