

ZILKHA RADIOLOGY - MEDICAL HISTORY

Mammography

Referring Doctor: _____

Other Doctors you want your results sent to: _____

Affix Label Here

BREAST IMAGING ONLY:

Are you allergic to Latex? **YES NO**

1. Reason for your exam today? **First Mammogram/Baseline Annual Exam Follow-up Exam New Breast Problem**

2. Date of Last Mammogram _____ Place _____
(It is the responsibility of the patient to bring prior mammograms from other facilities for comparison purposes)

3. Date YOUR doctor last examined YOUR breasts: _____ Results: _____

4. Are you currently having any breast problems? **YES NO**

Right: Pain/Tenderness Lump/Thickening Discharge/Bleeding Duration _____

Left: Pain/Tenderness Lump/Thickening Discharge/Bleeding Duration _____

5. Indicate if you have had: **Breast Implants Reduction Surgery** To: **RIGHT LEFT BOTH**
Other Breast Procedure _____ **When** _____

6. Have you ever had a Breast Biopsy? **YES NO**

Right: Surgical Biopsy Needle Biopsy Date _____ Results: **Benign Malignant**

Left: Surgical Biopsy Needle Biopsy Date _____ Results: **Benign Malignant**

7. Have you ever been diagnosed with breast cancer? **YES NO** If **YES**, how & when was it treated?

Right: Mastectomy Lumpectomy Radiation Therapy Chemotherapy Date _____

Left: Mastectomy Lumpectomy Radiation Therapy Chemotherapy Date _____

8. Please indicate which close family member, if any, has had breast cancer and the age it was discovered? **NONE**

Mother _____ **Sister(s)** _____ **Daughter(s)** _____

9. Has your weight changed significantly since your last mammogram? **GAINED LOST** Amount _____

Is there any chance you are pregnant at this time? **YES NO** Signature _____

Age of your first menstrual period? _____ Do you still menstruate? **YES NO** If **YES**, start date of your LMP? _____

If **NO**, at what age did you begin menopause? _____ If applicable, age of your first pregnancy? _____

Are you currently nursing? **YES NO** Have you been breast feeding in the last six months? **YES NO**

SMOKING:

Current; Every Day Smoker Former Smoker Smoker; Current Status Unknown

Current; Some Days Smoker Never Smoked Unknown If Ever Smoked

If Smoker, How many packs per day? _____ For how many years? _____

Are you taking any medications? **NO YES** List: _____

Do you have an allergy to medications?
NO YES List: _____

Authorization for Treatment: I hereby consent to treatment by the Radiologist and other medical staff for all radiological tests and/or procedures as deemed medically necessary by my referring physician.

I hereby state that the information listed above is accurate to the best of my knowledge.

Patient or Legal Guardian Signature _____ **Date** _____

Print Patient Name: _____ **Date of Birth:** _____

For Office Use Only: Co-pay _____

PACS _____ ADS _____ EMR _____

MAMMO _____
 DEXA _____
 FLXR _____
 US _____
 CT _____
 MR _____
 NM _____
 XR _____

Affix Label Here

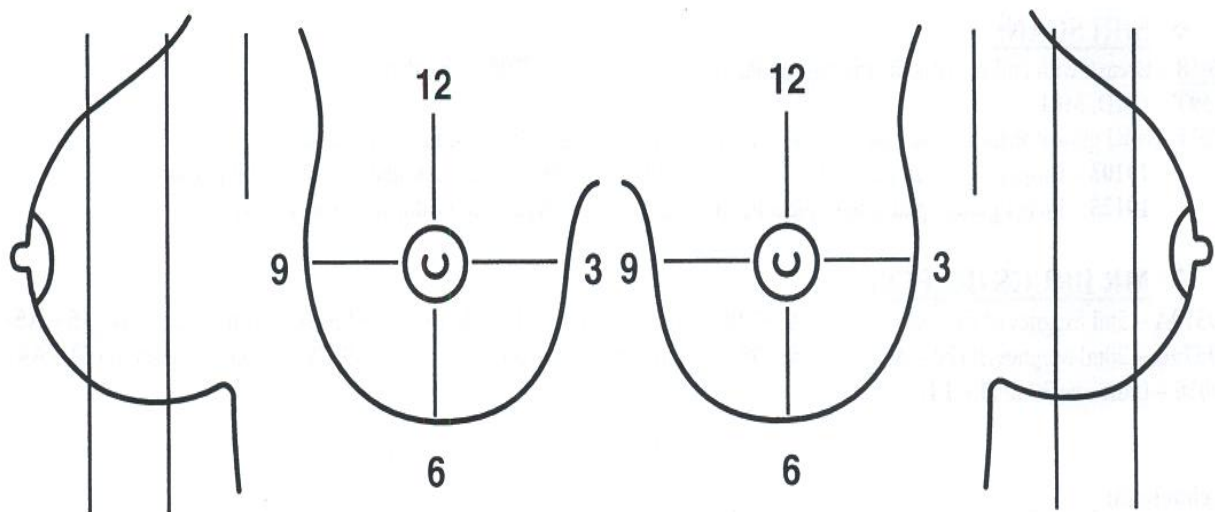
Technologist:	Priors: YES NO
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Posting/Coding:

CPT Code(s):	DX:
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Did the patient take **FILMS** or **DISC**? Were **FILMS** or **DISC** printed? Send to **EAST** or **WEST**?

ASYMMETRY	YES	NO	TENDERNESS	YES	NO	NIPPLE DISCHARGE	YES	NO
MASS(S)	YES	NO	SKIN MOLES	YES	NO	SCAR(S)	YES	NO



RIGHT

LEFT