

- BIC Mammo Add Views
- EIC Ultrasound Follow Up Exam
- WIC MRI



ACC#: _____

MRN: _____

Date: _____

Breast Imaging Form

Patient Name: _____ Age: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (_____) _____ Referring Physician: _____

Y N Prior Mammogram. Where: _____ When: _____

Y N Prior Breast Ultrasound. Where: _____ When: _____

Y N Prior Breast MRI. Where: _____ When: _____

What is the reason for today's exam? _____

Check all of the following RISK FACTORS that are true for YOU:

- I have had breast cancer.
- I have had endometrial cancer.
- I have had ovarian cancer.
- I have had previous chest radiation therapy.
- I have had a previous breast biopsy that showed a high risk lesion.
- I have had a significant weight loss or gain.
- I have been through menopause.
- I have never had children.
- I had my first child after age 30.
- I have BRCA1 gene mutation.
- I have BRCA2 gene mutation.
- I have a relative with BRCA gene mutation.

Menstrual Status: Last Menstrual Period: _____ Age of First Menstrual Period: _____

Y N Are you pregnant now? Number of pregnancies: _____ Age at first live birth: _____ Have you breast fed?: _____

History of Previous Breast Procedure (Breast Reduction, Cyst Aspirations, Biopsy, etc.)

Procedure	Side	Date Performed	Outcome
_____	_____	_____	_____
_____	_____	_____	_____

Y N Are you currently taking hormones? Hormone history: _____

Y N Implants? When: _____

Y N Family history of breast cancer: Mother Daughter Sister Grandmother Maternal Paternal Aunt Maternal Paternal
 Age: _____ Age: _____ Age: _____ Age: _____ Age: _____

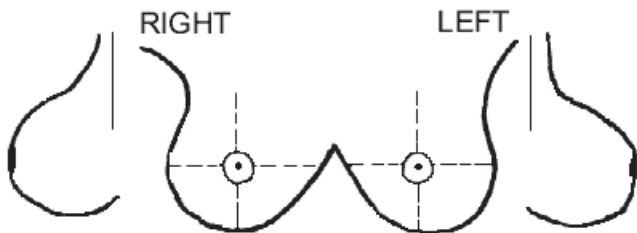
Date of Last Breast Exam by your physician: _____ **Do You Do Self Breast Examination Regularly?** _____

Comments: _____

Should the results of my mammogram require any type of surgical follow-up, I authorize **Associated Radiologists, P.A.** to obtain pathology results from my doctor / hospital / surgeon in accordance with the FDA under MQSA Guidelines and HIPAA.

 Patient Signature Date

Please Do Not Write Below This Line



- Routine Screening
- Pain
- Family History
- Technical Note _____
- Screening But See Note _____

Risk Assessment for MRI

Claus No. _____

BRCA _____

Chest Rad. Therapy _____

Safety:

Adequate shielding of patient Y N

Adequate shielding of Technologist Y N

Infection control procedures have been followed Y N

Technologist _____