

NAME: _____ **ADDRESS:** _____

DOB: _____ **AGE:** _____ **HOME #:** _____ **WORK #:** _____ **CELL #:** _____

DOCTOR NAME(S): _____ **Email:** _____

DATE: _____

Any chance that you may be pregnant? Yes No

Have you nursed a baby in the past 6 months? Yes No

Are you on hormone replacement therapy? Yes No

Have your Mother, Sister(s) or Daughter(s) had breast cancer? Yes No

If yes, was the breast cancer found before menopause? Yes No

Have you ever had breast cancer? Yes No

Have you had a significant weight gain/loss since your last mammogram? Yes No

Is there a personal or family history of Ovarian/Colon Cancer? Yes No

Have you had a prior Mammogram? Yes No
If so, where? _____

Do you or your Health Care Provider note a specific lump(s) in your breast now? Yes No
Left Right

Any discomfort, pain, or soreness? Yes No
Left Right

Any discharge from nipple? Yes No
If Yes, please describe. _____

Any persistent redness or skin thickening? Yes No
Left Right

Have you ever had a needle biopsy or cyst (needle) aspiration in the breast area? Yes No
If so, please explain. _____

Have you ever had any breast surgery including; lumpectomy, mastectomy, non cancerous biopsies or for cosmetic reasons? Yes No
(Cosmetic: Breast Implants, Breast Lift, Breast Reduction.)
If so, please explain. _____

I give permission to TPCA to obtain any previous mammograms and reports for comparison that may be needed.

I understand that my insurance company may not cover my exam, if it's been less than 366 days since my previous screening mammogram or if I'm called back for additional views or testing.

Have you ever had Radiation Therapy to the Breast area? Yes No
If so, please explain. _____

Patient Signature: _____

Please do not write below this line

Circle Exam:

Bilateral Screening Mammogram

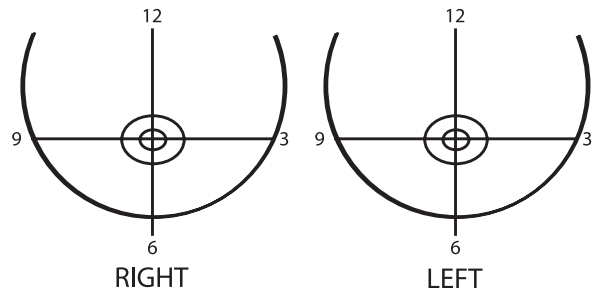
Bilateral Diagnostic Mammogram

Unilateral Screening Mammogram

Unilateral Diagnostic Mammogram

Diagnostic 6 month Follow-up: Bilat LT Only RT Only

Mammographer: _____



Mammography Order Sheet

Name _____ D.O.B. _____ Age _____

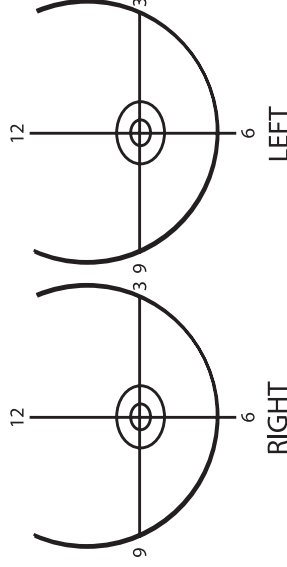
Ordering Practitioner _____

Appointment Date _____ Time _____

- Screening Mammogram (with ultrasound if needed)
- Diagnostic Mammogram (Patient or practitioner feels a lump, follow-up of a mammographic abnormality, focal persistent pain, personal history of breast cancer, new nipple inversion or discharge, or current mastitis) with ultrasound if needed.

Breast Ultrasound

Relevant History _____



IMPORTANT
Please mark the location of palpable lumps.

For your comfort, we suggest you schedule your appointment after your menstrual cycle if possible. If your appointment is at an inappropriate time, we will be happy to reschedule for you.

Preparation

- Do not use deodorants, body powders, perfumes or body lotions around your breasts and underarms
- For your convenience and comfort, please wear a two piece outfit.
- If you have had a previous mammography examination please attempt to obtain the x-rays before your appointment. It is very important to use the previous examination for comparison. If the previous mammograms were done at an out-of-town institution, please have them mailed to our address. We will assume the responsibility of returning the x-rays.