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? ______________________

____

____

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.

Patient Signature: ______________________

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 Left Right
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 Left Right
If so, please explain. ______________________

____

____

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

____

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

____

____

Please do not write below this line

Circle Exam:

Bilateral Screening Mammogram

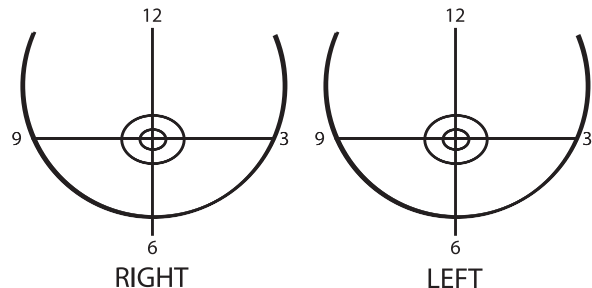
Bilateral Diagnostic Mammogram

Unilateral Screening Mammogram

Unilateral Diagnostic Mammogram

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

Mammographer: ______________________



Tallahassee Primary Care Associates, P.A. (TPCA) does not discriminate on the basis of race, color, national origin, sex, age or disability in its health programs or activities.

TPCA Tallahassee Primary Care Associates Diagnostic Imaging Center

Our primary care is you.

1803 Miccosukee Commons Drive
Tallahassee, Florida 32308
(850) 942-6624

Mammography Order Sheet

Name ______________________ D.O.B. ________ Age _____

Ordering Practitioner ______________________________

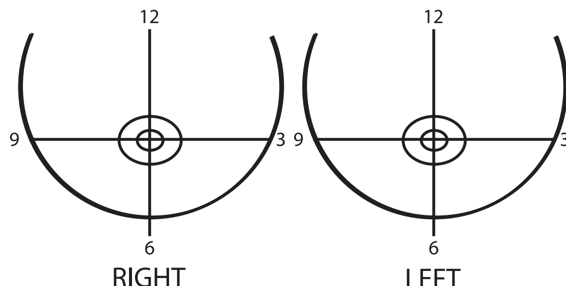
Appointment Date ______________________ Time ________

- [ ] 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

1. Do not use deodorants, body powders, perfumes or body lotions around your breasts and underarms
2. For your convenience and comfort, please wear a two piece outfit.
3. 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.

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Clinical Laboratory
Diagnostic Center

(850) 942-6624
Scheduling Fax: (850) 224-3429