Medical Park Imaging at Wayne - Denville - Newfoundland

Mammography Data Form Date:_____

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

Address:_____ City:_____

Phone:(_____)_____ State:_____Zip:_____

Referring Physician:_____

PATIENT DATA

◯Y ◯N Prior Mammogram Where:_____When:_____

◯Y ◯N Prior Breast Ultrasound Where:_____When:_____

◯Y ◯N Are You Taking Hormones?_____Menstrual Status: Last Menstural Period_____

What age did you start menstruating:_____

◯Y ◯N Are you pregnant now? Number of Pregnancies_____Age at first Live Birth:_____

◯Y ◯N **PREVIOUS BENIGN BREAST SURGERY**: (SURGERIES, BIOPSIES, ASPIRATIONS)

Aspiration: Right_____ When:_____ **Biopsy**: Right_____ When:_____ Result:_____

Left_____ When:_____ Left_____ When:_____ Result:_____

◯Y ◯N Implants: When:_____

◯Y ◯N **PERSONAL HISTORY OF BREAST CANCER**: When?:_____

Mastectomy: Right_____ When:_____ **Lumpectomy**: Right_____ When:_____ Result:_____

Left_____ When:_____ Left_____ When:_____ Result:_____

Radiation Therapy?:_____When:_____

◯Y ◯N **FAMILY HISTORY OF BREAST CANCER:** ◯Mother ◯Daughter ◯Sister ◯Grandmother ◯Aunt

_____Age _____Age _____Age _____Age Maternal / Paternal _____Age Maternal / Paternal

Is this a routine mammography ◯Y ◯N

Is this a problem mammography ◯Y ◯N

Screening: ◯Baseline ◯Routine

Diagnostic: ◯Bilateral ◯Unilateral

Present Complaint: ◯New Lump ◯R ◯L ◯Pain ◯R ◯L

Nipple Discharge ◯R ◯L ◯Swelling ◯R ◯L

◯Nipple Retraction ◯R ◯L ◯Follow-Up ◯R ◯L

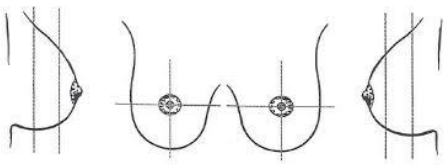
Should the results of my mammogram require any type of surgical follow-up, I authorize Medical Park Imaging to obtain pathology results from my doctor/hospital/surgeon in accordance with the FDA under MQSA guidelines.

X_____ _____

Patient Signature Date

Signature:_____

For Technologist:



Right Left

Films compared to prior study of:

Prior films read by:_____or_____outside films

Technologist:_____

THE PATIENT WAS NOTIFIED OF THE RESULTS AT TIME OF VISIT ◯Y ◯N

Y – if a letter was given to the patient before leaving

N – if a letter will be mailed to the patient

Safety:

Adequate shielding of patient ◯Y ◯N

Adequate shielding of the technologist ◯Y ◯N

Infection Control Procedures have been followed ◯Y ◯N