

MAMMOGRAM REQUEST

Name: _____ Chart # _____ Date of Birth _____

Ordering Physician: _____

Personal History

Age of first menstrual period _____ Age when you had your first child: _____

If post-menopausal, age of last menstrual period: _____ Do you take hormones? _____

Family History

Do you have any family members who have or have had breast cancer? If so, please provide information below:

Relationship	Age of Diagnosis:
_____	_____
_____	_____
_____	_____

Interim History:

When did you have your last mammogram? _____
Where? _____
Do you perform monthly breast examinations? _____
Do you take Birth Control? _____
Are you pregnant? _____ Date of Last menstrual period _____

Past Breast History

Please circle Y or N. If yes, indicate which breast and date.

Have you had
 Y N a biopsy? Right ___ Left ___ Date _____
 Y N a cyst drained? Right ___ Left ___ Date _____
 Y N breast cancer? Right ___ Left ___ Date _____
 Y N breast reduction surgery? Right ___ Left ___ Date _____
 Do you have implants? _____ moles on your breasts _____
 Has there been a change in your breasts since your implant surgery _____

Current Breast History

Do you have
 Y N a lump? Right ___ Left ___ Date _____
 Y N nipple discharge? Right ___ Left ___ Date _____
 Y N nipple bleeding? Right ___ Left ___ Date _____
 Y N unusual pain or tenderness? Right ___ Left ___ Date _____
 Have you ever been told you have a Fibrocytic Breast? _____

Technologist's Notes

Date of exam: _____
 Chart No: _____
 Clinical History: _____

 Angle _____ Tomo _____
 Technologist _____
 Additional Views _____

 10x12 _____ 8x10 _____

NOTICE AND RELEASE

You may be notified that additional studies are needed. This is NOT an indication that you have breast cancer. The radiologist calls back approximately 15% of all patients for additional studies, and 80% of those are normal upon closer examination. These additional studies are ordered to provide you with the most accurate diagnosis. **Should you require additional follow-up, contact your physician's office to help you in scheduling your appointment. It is important that you contact your insurance company before calling for your appointment to ask which facility is approved on your insurance plan. Your physician will need this information before referring you for your follow-up.**

I authorize Women's Care Center of Memphis to release my medical records, including x-rays, to the facility, and its contracted radiologist, approved by my health plan for the purpose of comparison.

Patient Signature

Date

Patient Name (Print)

Home Phone #

Street or Mailing Address

Work Phone #

City

State

Zip Code

Cell Phone #

In the event that we need to contact you about this study, which of the above listed numbers should we use? _____

Should you need follow-up studies, is anyone, other than you, authorized to pick up your films? If so, please give name and relationship.

Name

Relationship

Name

Relationship