RADNET MANAGEMENT, INC.

History Form

MAM.POL.002
Mammography Manual / Regulatory Affairs
Effective Date: June 5, 2014

BREAST HISTORY

Name: ______________________ Age: ________ Date: ____________

Referring Doctor: ______________________ Imaging Center: ______________________

Reason for this examination: ______________________

Have you had a Mammogram / Ultrasound before? ☐ Yes ☐ No When? __________ Where? __________

Have you ever had a Breast MRI before? . . . . ☐ Yes ☐ No When? __________ Where? __________

PHYSICAL CONCERNS

			Right	Left	How Long?
Do you feel a lump?	☐ Yes	☐ No	______	______	______
Is this a new finding?	☐ Yes	☐ No	______	______	______
Focal or specific point of pain?.	☐ Yes	☐ No	______	______	______
Have you had recent trauma to a breast?	☐ Yes	☐ No	______	______	______
Nipple discharge or retraction?	☐ Yes	☐ No	______	______	______
Skin dimpling?	☐ Yes	☐ No	______	______	______

Additional Information: ______________________

BREAST SURGICAL HISTORY

			Right	Left	Month / Year
Previous Breast Cancer	☐ Yes	☐ No	______	______	______
Mastectomy	☐ Yes	☐ No	______	______	______
Lumpectomy (cancer)	☐ Yes	☐ No	______	______	______
Radiation Therapy	☐ Yes	☐ No	______	______	______
Chemotherapy	☐ Yes	☐ No	______	______	______
Biopsy (Needle or Surgical)	☐ Yes	☐ No	______	______	______
Needle Aspiration	☐ Yes	☐ No	______	______	______
Reconstruction / Reduction	☐ Yes	☐ No	______	______	______
Implants or Silicone Injections	☐ Yes	☐ No	______	______	______

Additional Information: ______________________

GENERAL HISTORY

Are you pregnant?. . . . . ☐ Yes ☐ No

Breast fed within last 4-6 months?. . . . . ☐ Yes ☐ No

Any family history of breast cancer?. . . . ☐ Yes ☐ No

Which relative and age? ______________________

Have you had any other type of cancer? ☐ Yes ☐ No

If yes, what kind? ______________________

Age at your first full term pregnancy? ________ Years

MENSTRUAL HISTORY

1st day of your last period: ______________________

Menopause?. . . . ☐ Yes ☐ No

Hysterectomy?. . . ☐ Yes ☐ No

Are you taking hormones or birth control pills? ☐ Yes ☐ No

If yes, what kind? ______________________

If yes, how long? ______________________

Additional Information: ______________________

OFFICE USE ONLY

Clinical Findings

Clinical indications/Notes:

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____

Technologist's Name: ______________________

1. On review of your screening mammogram, if an area needs further evaluation, we will contact you to schedule an appointment. (There is an additional charge for these views).
2. If an ultrasound exam is recommended, this is considered a separate study and is billed separately.
3. In the event that additional views and/or breast ultrasound is performed on the same day as your screening mammogram, be aware that there is an additional charge for these exams.

PLEASE BE ADVISED THAT A DIAGNOSTIC MAMMOGRAM AND/OR BREAST ULTRASOUND ARE NOT CONSIDERED TO BE A ROUTINE PREVENTATIVE EXAM AND MAY INCUR ADDITIONAL OUT OF POCKET EXPENSE.

To the best of my knowledge, all of the above is true and correct.

Patient Signature: ______________________ Date: ______________________