

acility:	Radiology Imaging Associates			

History Form

MAM DOL 001

	Mammograpl		Regulatory Affai Pate: June 1, 200	
Name:	Age:	Date:		
Referring Doctor:				
Reason for this examination:				
Have you ever had a Mammogram / US before?	es No When?	Whe	re?	
Have you ever had a Breast MRI before?	es No When?	Whe	re?	
PHYSICAL CONCERNS	Right	Left	How Long?	
Do you feel a lump?	7			
Is this a new finding?	□ NI=			
Focal or specific point of pain?	7 No			
Have you had recent trauma to breast? Yes	No			
Nipple discharge or retraction?	No			
Skin dimpling?	No		-	
Additional Information:				
BREAST SURGICAL HISTORY	Right	Left	Month / Year	
Previous Breast Cancer Yes	No			
Mastectomy Yes	7			
Lumpectomy (cancer)	No			
Radiation Therapy Yes	No			
Chemotherapy Yes	No			
Biopsy (Needle or Surgical)] No			
Needle Aspiration Yes	No			
Reconstruction/Reduction Yes				
Implants or Silicone Injections Yes	No	-		
Additional Information:				
SENERAL HISTORY		MENSTRUAL PERIODS		
Are you pregnant?] No Menopau		☐ No	
Breast fed within last 4-6 months?	No Hystered		☐ No	
Any family history of breast cancer? Yes	No Are you t	taking hormones /		
Which relative?Age?	7	24.00.12	∐Yes ∐ No	
Have you had any other type of cancer? Yes				
If yes, what kind?	For how	long?		
Additional Information:				
OFFICE USE ONLY Clinical Findings	al indications/Notes:			
	echnologist's Name:			

- 1. On review of your screening mammogram, if an area needs further evaluation, there is an additional charge for these views.
- If an ultrasound examination is recommended, this is considered a separate study and separate charge.
 To the best of my knowledge, all of the above is true and correct.

Patient Signature:	Date: