CHOICE *Diagnostic Imaging*

MAMMOGRAPHY INTAKE

PLEASE PRINT. THANK YOU!

First: _____ MI: _____ Last: _____

Have you had a change of address from your last visit? YES NO

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

Date of Birth: _____ Age: _____ Weight: _____ ☐ MALE ☐ FEMALE

PLEASE CIRCLE EACH ANSWER...

Have you had a previous mammogram? YES NO

If YES, what was the name of the facility? _____

Facility's Address: _____ Phone: _____

Date of your prior mammogram: _____

Have you ever been diagnosed with breast cancer? YES NO RIGHT LEFT

If YES, what year was your first diagnosis? _____

Are you taking any of the following hormones?

	YEAR STARTED
Tamoxifen / Raloxifene.....	_____
Hormone Replacement	_____
Natural Hormones.....	_____
Birth Control Pills	_____
Other _____	_____

Have you had a hysterectomy? YES NO When? _____

Were both ovaries removed? YES NO

Have your mother, sisters, daughters, aunts or grandmothers had breast cancer? YES NO _____

Have you had previous breast surgery, biopsies or Breast Implants? YES NO _____

_____ _____

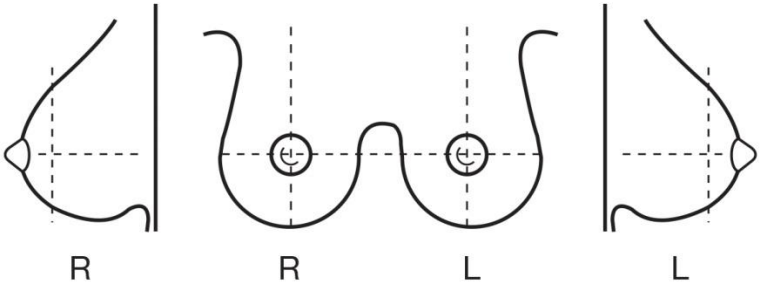
Patient Signature *(Guardian / Parent If A Minor)* Date

TO BE COMPLETED BY TECHNOLOGIST

Study Date: _____ Acc # _____ Technologist _____ Screening? ☐ Y ☐ N Diagnostic? ☐ Y ☐ N

Additional Views: Right _____ Left _____

6 Month Followup: Right _____ Left _____



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