Technologist_________ Doctor___________

Date___________ Medical Record Number_____________

Name: ____

Date of birth: _________________ Age: _____

Ethnic Group: Black______White: ____Hispanic_____ Native American____ Other______

Previous Mammogram: Yes: _____ No: _____

Location of last mammogram: Rocky Mount Family Medicine_____ Nash Breast Care_________
Boice Willis Clinic__________ Rocky Mount OBGYN_________ Other (specify)_____________

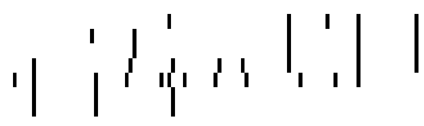
Was your last mammogram over 12 months ago? _______Initials_________
(**Most health insurance will only pay for one screening mammogram every 12 months**)

Do you have a family history of breast cancer? ____ Who? __________________ Age at diagnosis? _______

Have you had breast cancer? Yes ____ No: ____
Have you ever had surgery or a biopsy performed on either breast? (Please check all that apply)

	R	L	B	YEAR
Cyst Aspiration				
Surgical Biopsy				
Needle Biopsy				
Mastectomy				
Lumpectomy				
Implants				
Breast Reduction				
Other				

No history of breast problems _______



Current breast problems? No__________Yes ___________ **(This is a screening facility only. If you are experiencing problems we will refer you to another facility).**

Are you on hormones? ___________ Have you ever been on hormones? ______

What Kind? _____________ How long?____________

Date or age of last menstrual period__________________**(please put approximate age if post-menopausal!!! Or age if you have had a hysterectomy)**

Is there any possibility that you may be pregnant? ______ Initials_______

Have you had a hysterectomy? _________ Were both ovaries removed? _________________

Dear Mammography Patient,

A screening mammogram is an exam performed as part of a wellness program. It is performed every 12 months or less often as determined by your primary care physician. A screening mammogram should **NOT** be done more often than every 12 months. Generally insurance companies will only pay for a screening mammogram every 12 months. **You will be required to pay for any charges not covered by your insurance.** You should keep the dates in your records and be sure to schedule each mammogram 12 months plus one day from the last. **Diagnostic mammograms are performed if you are having some type of problem, and are not performed at this facility. Patients with breast implants will also be referred to another facility. If you have a PERSONAL history of breast cancer you will need to be referred to another facility.**
Please advise technologist if there is any possibility that you may be pregnant.

It is important that you complete your history form to the best of your knowledge. This keeps your mammography record updated and better enables the radiologists when they are viewing your films. It is important to update your history at each annual mammogram.

If the last mammogram you had was not done at Rocky Mount Family Medical Center you will be asked to fill out a release form. The radiologist needs the **LAST** mammogram that was performed on you so that he can compare it to the one we do today. The form will ask you to designate permanent release or temporary release. If you choose permanent release it means that after the radiologist has read today's films and compared them to the previous films, we will keep them here as part of your permanent mammogram record until you request that they be forwarded to another facility. If you choose temporary release it means that after your films have been read we will mail all the previous films back to the facility that they came from. Please advise the Technologist if you had your last mammogram at Boice-Willis Clinic as they require a separate release form. If your last mammogram was not performed locally you will need to provide some type of contact information so that we can fax a release form to that facility. It also will expedite the procedure if you call and request the films be transferred here yourself, but it is not necessary. In some cases in can take several weeks to receive films.

You should receive results within 30 days by mail. If additional views are required I will make every attempt to contact you by telephone prior to mailing the letter. Your exam is considered incomplete until the additional views are obtained.

Thank you,

Radiology Department

Patient Signature____

(I acknowledge that I have read the above form and agree with the terms)

Date___________________